Department of Health

Durham University

A Profile of Children's Health and Maternity Services in England 2006

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Contents

Foreword

The National Child Health and Maternity Services Mapping Project was launched on 1st November 2005. It is the first attempt to understand the range, nature and extent of children's health services in England and using annual data returns it will enable us to track changes in the coming years. It represents groundbreaking work both nationally and internationally.

This 'live' exercise takes current data supplied by the services themselves to develop a description of how children's and maternity services are commissioned and provided. The exercise is completed online by services at www.childhealthmapping.org.uk. The results are posted on the website to provide a valuable resource for managers, clinicians, commissioners and policy makers to help inform decisions about the development of children's services on a regular basis.

Demand for the exercise originated from child health leaders themselves. They recognised that an essential requirement to tackle the perceived inequalities in children's provision and implement national policy was the availability of robust information on current services which could be understood in the context of the needs of the population and compared with other localities. As a consequence this project was developed giving it national benchmarking capabilities.

The primary purpose of the exercise is to support the implementation of the national child policy agenda, in particular the National Service Framework for Children, Young People and Maternity Services and Every Child Matters. Formally the Child Health and Maternity Services Mapping Project is part of the Change for Children Programme and is set out in the national implementation plan, 'Supporting Local Delivery'.

This national atlas of data about child health and maternity services is the first output from the exercise and provides national data against a number of key issues. There are three sections.

Firstly, a focus is given to the planning and commissioning of child health and maternity services as this is a significant issue for us. The section sets out a number of key challenges in the resourcing of children's services and the way in which we prioritise the planning for them within our own organisations. Predictably there are huge variations around the country and we would hope to see this change over time.

Secondly, the description of services gives an outline of the range of children's health and maternity services available in the country. Over 3,000 services have been mapped providing a rich profile of national provision. Again this illustrates the wide variation across Strategic Health Authority areas.

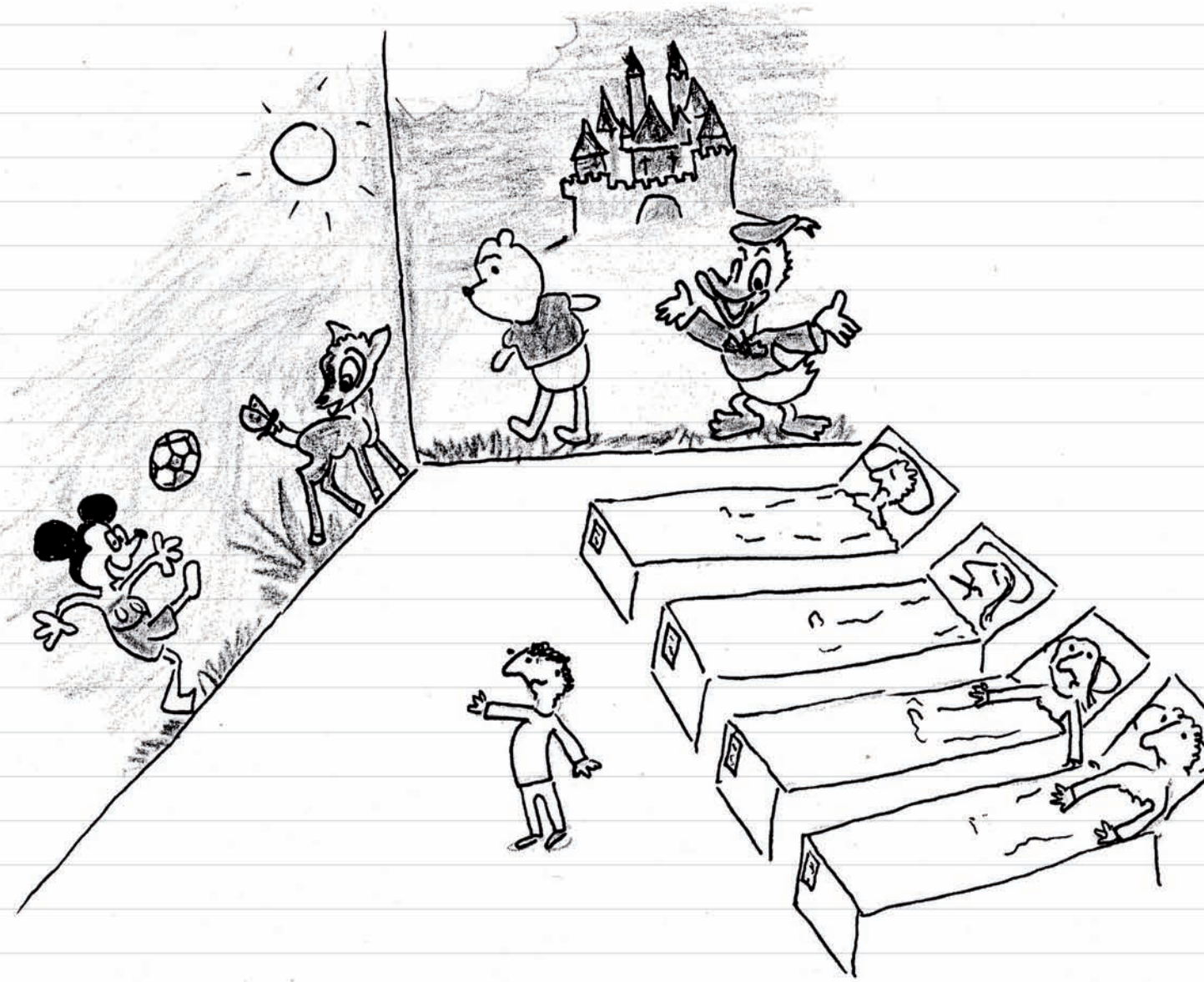
Thirdly, a chapter on policy imperatives gives us a baseline position against a number of national policy targets. In establishing the baseline position, it is possible to see the extent of change still required to meet policy goals.

Other products planned are a regional atlas setting these same issues into a regional context, local workbooks which take into account other sources of data and finally some national reports on key themes such as maternity services and interface issues between health and social care. You can access all information on the website as it becomes available. It is also likely that the data will be part of the developing national performance monitoring agenda through the Healthcare Commission.

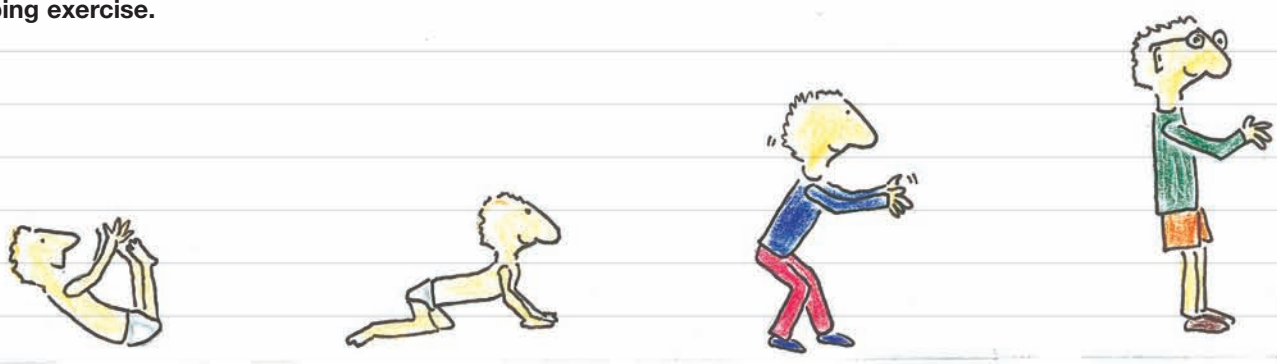
This is the first year of child health and maternity service mapping information and while we have benefited from mapping technology developed over the last five years in other areas, we fully expect data to improve as organisations become familiar with what is being requested. I think you will agree though that this provides us with a remarkable start to the implementation of this radical reform agenda for children.

Many thanks indeed to the team behind it all and all of you who have contributed.

Dr Sheila Shribman
National Clinical Director for Children
Department of Health



Thanks to Josh Rigg of Durham Johnston School for the artwork showing his interpretation of the NHS Children's Services included in the mapping exercise.



Chapter 1:

Executive summary and key messages

1.1 Introduction

This is an executive summary of the national profile of child health and maternity services drawn up from the findings of the 2005/6 child health and maternity service (CH&MS) mapping exercise. It gives information at a national and SHA level only but data by PCT and other NHS provider trusts is available on the mapping website at: www.childhealthmapping.org.uk/reports.

1.2 Overview

The first national child health and maternity service mapping exercise was carried out between November 2005 and February 2006. The exercise is annual and is commissioned by the Department of Health. It sits within the Change for Children Programme with the following aims:

- To provide a baseline of current service provision against which future change can be measured as the National Service Framework for Children, Young People and Maternity Services and other national policy is implemented
- To support local benchmarking on costs and the nature of service provision
- To provide information needed for Children's Trusts and joint commissioning strategies
- To support performance management
- To generate local and national service directories.

The mapping is an on-line data collection system that captures information on 15 service types in 4 categories: universal; targeted; hospital; and maternity services. Nominated contacts within PCTs and other NHS provider trusts were asked to submit descriptions of the services they provide so that a database of national child health and maternity services could be built up. PCT commissioners were asked to supply information on actual spend on these services for the financial year 2004/5 and the predicted budget for the financial year 2005/6.

1.3 Purpose of the report

This national mapping exercise was an ambitious project involving over 1,500 staff inputting data across children's health and maternity services in England. In addition, it was the first year of the exercise and new to everyone involved. Given the complexity of the coverage there are a number of data issues that should be considered when interpreting the results:

- Complete data has not always been entered
- The requirements of the exercise may have been interpreted in different ways
- As data is not traditionally collected in the format requested, reliance had to be placed on estimates in many localities
- The data is for dedicated children's health services only and not for generic services that provide for all ages.

Despite these limitations, interesting results are reported and much work is being done to improve the quality of the mapping data in future exercises.

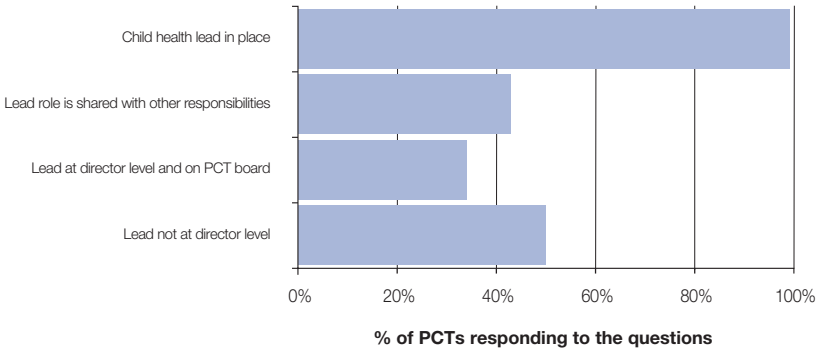
1.4 Planning, commissioning and finance

1.4.1Leadership

Overall, 240 of the 303 PCTs in England responded to these questions. Of the PCTs who responded, all but two were found to have a lead officer with responsibility for child health.

- In 43% of responding PCTs the child health lead was a role shared with other responsibilities (Fig. 1.4a)
- In 41% of PCTs the child health lead was at director level but the lead was a member of the PCT board in only 34% of PCTs
- In 50% of PCTs the child health lead was at a level below director.

Fig. 1.4a: Child health leadership in PCTs (N=240)

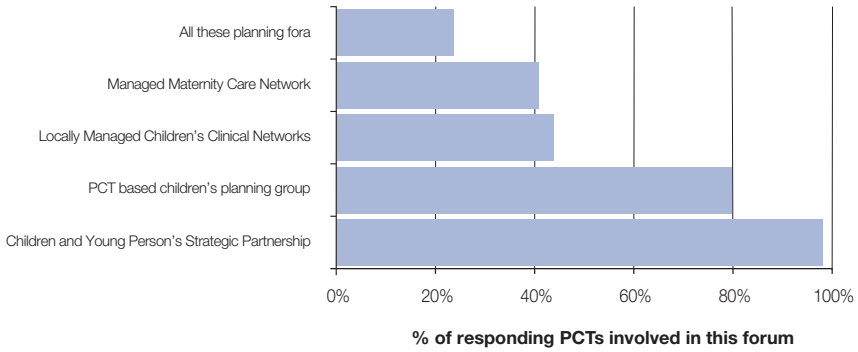


1.4.2 Involvement in planning fora

Of the 238 PCTs that completed the questions on engagement in clinical and strategic planning networks it was found that:

- All but 5 PCTs actively participated in their local Children and Young Person's Strategic Partnerships indicating joint working with local authorities (Fig. 1.4b)
- 81% of PCTs were running PCT-based children's health planning groups
- Only a minority of PCTs contributed to locally managed clinical and maternity care networks.

Fig. 1.4b: PCT involvement in planning fora (N=238)



1.4.3 Completion of assessment of need

Full child health assessments of need had been completed by 54% of responding PCTs. The best covered elements were population, deprivation analysis and assessment of the needs of vulnerable groups, such as, looked-after children, children with mental health problems and children on the child protection register (Fig. 1.4c).

Fig. 1.4c: % of PCTs completing elements of a child health needs assessment (N=238)

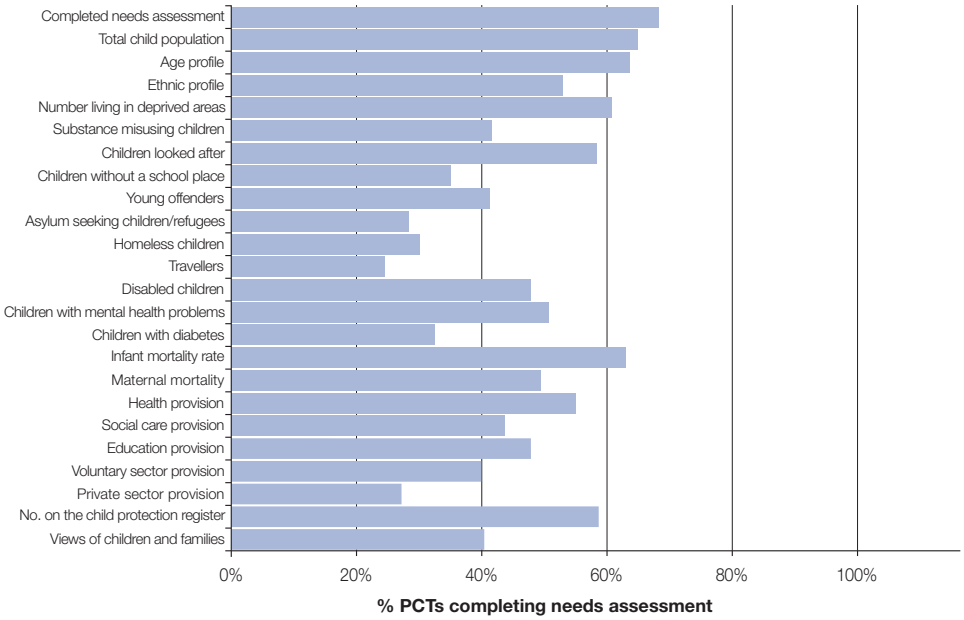
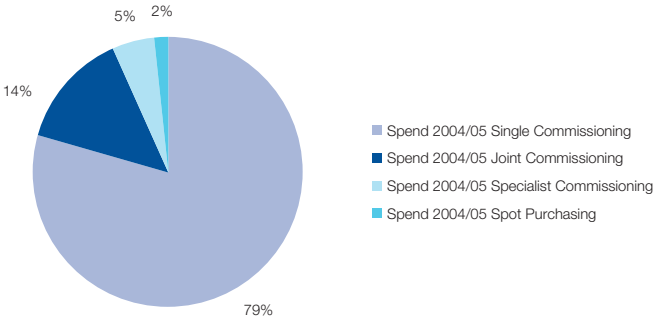


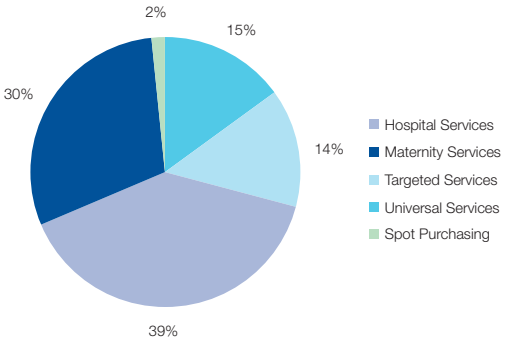
Fig. 1.4d: 2004/5 budget by commissioning type



1.4.4 Commissioning arrangements

The majority of child health services were commissioned through single PCT commissioning arrangements in 2004/5. 79% of the 2004/5 budget was spent in single commissioning arrangements (Fig. 1.4d). Joint commissioning accounted for 14% of the budget, specialist commissioning accounted 5% and spot purchasing 2%.

Fig. 1.4e: Reported 2004/05 child health and maternity service spend by service category

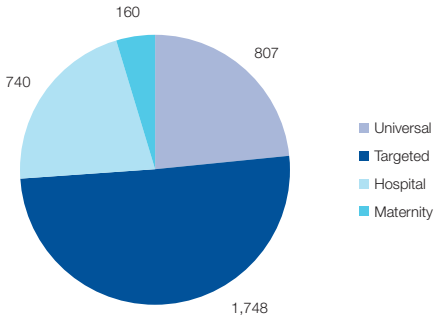


1.4.5 Finance

The finance section of the mapping was completed by 270 PCTs. Total reported spend on dedicated child health and maternity services in 2004/5 was in excess of £3,100M. Of this, 39% was spent on hospital services, 30% on maternity services, 15% on universal services and 14% on targeted services (Fig. 1.4e). Spend on child health and maternity services was expected to increase in 2005/6 by 6% on universal services, 7% on targeted services, 11% on hospital services and 7% on maternity services.

1.5 National profile of child health and maternity services

Fig. 1.5a: Number of services mapped in each category (N=3,455)



1.5.1 Service provision

Of the 3,455 services mapped, 807 (23%) were universal services, 1,748 (51%) were targeted services, 740 (21%) were hospital services and 160 (5%) were maternity services (Fig. 1.5a).

Services were mapped to 15 service types within the 4 main categories (Fig. 1.5b).

Fig. 1.5b: Number of services mapped by service type (N=3,455)

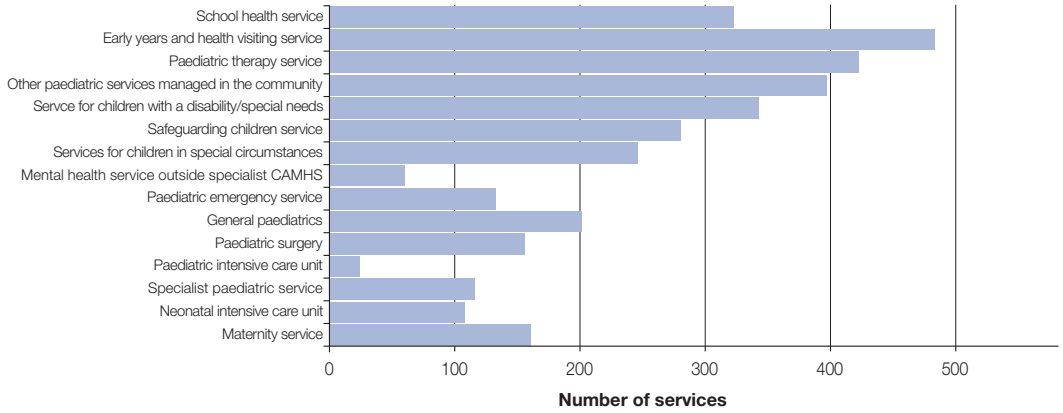
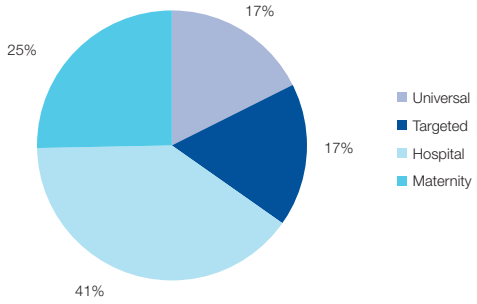


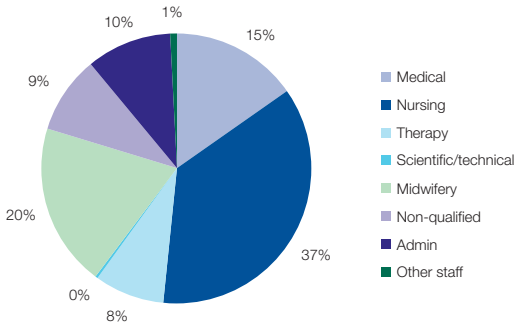
Fig. 1.5c: Size of the child health and maternity service workforce by service category (N=83,558 WTE)



1.5.2 Workforce

The total workforce for dedicated child health and maternity services was reported as 83,558 WTE. Of this total,14,507 WTE (17%) worked in universal services, 14,594 WTE (17%) in targeted services, 33,221 WTE (41%) in hospital services and 21,236 WTE (25%) in maternity services (Fig. 1.5c).

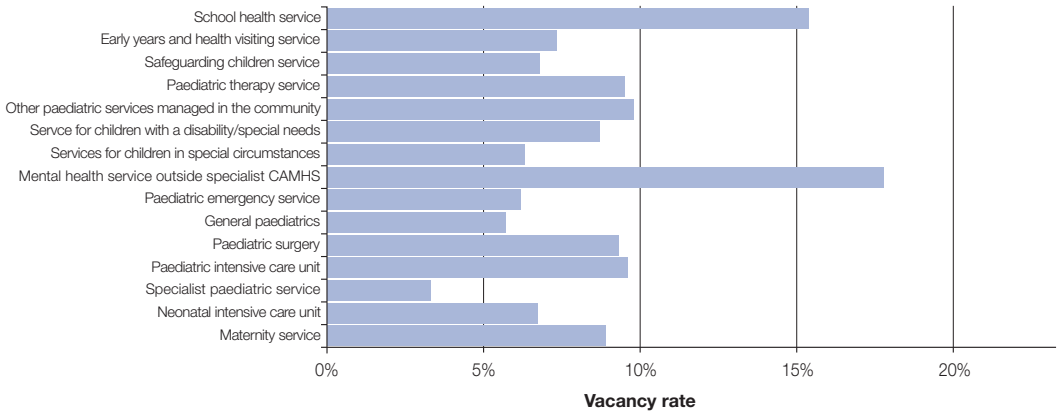
Fig. 1.5d: Child health and maternity service workforce by profession (N=83,558 WTE)



Nursing staff accounted for 30,324 WTE (36%) of the workforce, midwifery staff 16,448 WTE (20%), medical staff 12,854 WTE (15%), therapists 6,901 WTE (8%) and administrative staff 10% (Fig. 1.5d).

The average vacancy rate amongst the child health and maternity service workforce was 8%. This ranged from 3.3% in specialist paediatric services to 17.8% on mental health services outside specialist CAMHS (Fig. 1.5e).

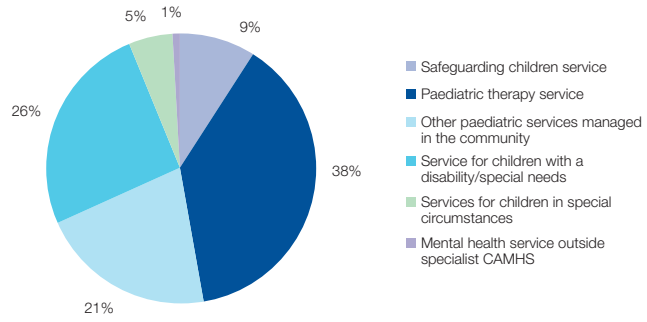
Fig. 1.5e: Vacancy rates by service type (N=91,137 WTE)



1.5.3 Universal services

- Universal services were predominantly provided by PCTs. 82% of PCTs in England reported having a service
- Early years and health visiting services accounted for 60% of the services and 76% of the workforce. School health services accounted for 40% of the services and employed 24% of the staff
- 70% of the universal service workforce were nurses
- Early years and health visiting services tended to be based in community and primary care health settings. Sure Start/Children's Centres were the main base for 20% of services and the location of outreach work for a further 40%. School health services were most often based in health settings or schools and their work was concentrated in schools, including extended schools.

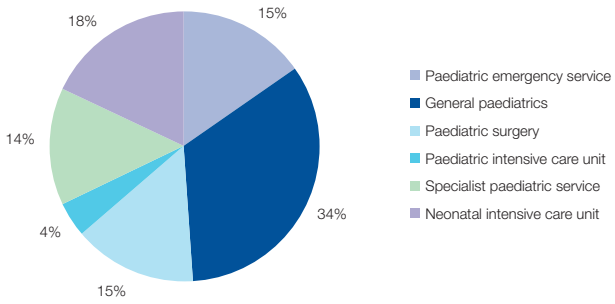
Fig. 1.5f: Targeted services workforce by service type (N=14,478 WTE staff)



1.5.4 Targeted services

- Paediatric therapy services employed 38% of the targeted service workforce while services for children with disabilities employed 26%, paediatric services managed in the community employed 21% and services for safeguarding children employed 9% (Fig. 1.5f)
- The majority of targeted services (80%) were provided by PCTs
- Targeted services were predominantly based in community health and hospital settings while outreach work extended the work of many services into social services, education and early years service settings.

Fig. 1.5g: Hospital services workforce by service type (N=33,221 WTE staff)

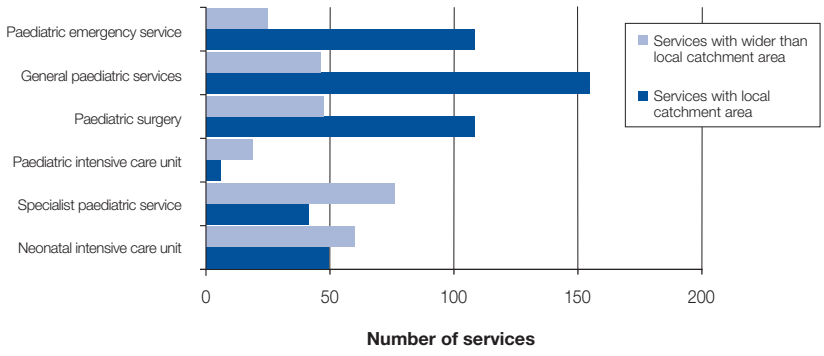


1.5.5 Hospital services

- Of these, general paediatric services and paediatric surgery accounted for 34% of the reported hospital service workforce (Fig. 1.5g), neonatal services for 18%, paediatric emergency services for 15%, specialist paediatric services for 14% and paediatric intensive care for 4%

- Emergency services, general paediatrics and paediatric surgery were mainly commissioned to provide a service for a defined local population whilst PICU, specialist paediatric services and NICU tended to provide services for a wider than local catchment area (Fig. 1.5h).

Fig. 1.5h: Catchment served by hospital services (N=740)



1.5.6 Maternity services

- Altogether 160 maternity services were mapped employing 25% of the child health and maternity service workforce (21,250 WTE). Of these, 97 services (61%) served a local catchment area while 63 services (39%) served a wider regional or sub-regional area
- On the model of care, 88% of services provided consultant-led care and 95% midwifery-led care. 13% of services were solely midwifery-led and 6% solely consultant-led
- In total 6,941 maternity beds were mapped in 146 maternity services of which 46% were postnatal beds, 21% antenatal beds and 24% were in delivery suites. Special care baby units had a capacity of 1,305 cots but special care cots are also provided in some neonatal intensive care units which had a total national capacity of 2,000 cots
- This maternity provision gives a national average of 59 births per maternity bed.

1.6 Progress against national child health policy

1.6.1 Standard 1 - Promoting Health and Well-being, Identify Needs and Early Intervention

- 154 PCTs (64% of respondents) had a public health strategy in place
- Wide variation was found in the time spent by universal services on public health activities
- Extended nurse roles had been developed in universal services in a number of areas: 76% of services had nurses with a special interest in public health, 71% in parenting programmes and 69% in immunisation. Nurses in early years and health visiting services were more likely to extend their role into sleep and other behavioural needs (63%) and post-natal depression (80%). School health nurses had a greater role in the provision of continence services (80%) and supporting children with particular conditions such as asthma (51%)
- All types of nurse prescribing were well developed in early years and health visiting services while school health services focused on the use of patient group directions
- 192 (59%) school health services provided less than 1 school nurse per secondary school and cluster of primary schools, 50 (15%) provided between 1 and 2 WTE nurses and 9 (3%) services provided over 2 WTE nurses per cluster
- 219 PCTs (92% of respondents) had arrangements for neonatal hearing screening in place.

1.6.2 Standard 5 – Safeguarding and Promoting the Welfare of Children and Young People

- Overall, 43% of PCTs and 62% of other NHS trusts providing children's services reported having a named doctor, while 74% of PCTs and 67% of other NHS trusts reported having a named nurse
- Safeguarding children was reported as a focus of work in all universal and targeted service types to a lesser or greater extent
- The range of safeguarding services in which full support was provided 24 hours a day, 7 days a week varied widely. Information and advice was available 24/7 in 65% of safeguarding services and child protection medical examination in 47%. A telephone answering service was available in 58% of services and a next day response in 45%.

1.6.3 Standard 6 - Children and Young People who are ill and Standard 7 - Children and Young People in Hospital

- The range of paediatric emergency services provided varied widely with only 22% of services having dedicated stand alone emergency services for children
- 82% of general paediatric services offered inpatient care and 87% outpatient care. 74% of services offered both types of care
- Alternative models of care for inpatient provision varied widely with specialist nursing provision being the most common, found in 81% of general paediatric services
- 86% of the general paediatric services mapped provided diabetes care. All services managed Type 1

diabetes while 85% managed children and young people with Type 2 diabetes. 160 services (93%) provided outpatient care, 158 (92%) provided inpatient care and 123 (72%) provided outreach

- 92% of general paediatric services for diabetes had access to a dietician. 91% of services had access to a nurse specialist, 56% had access to a diabetologist and 49% had access to an endocrinologist
- Currently 149 of the 155 paediatric surgery services mapped (96%) offered day surgery but there were some significant differences in the staffing of these services
- In total 2,085 WTE medical staff were employed in the paediatric surgery services mapped of whom 249 WTE were consultant surgeons who had received child specific training
- The total number of surgery cases carried out in the last 12 months was 189,745. This equates to 17 cases per 100k population of 0 to 17 year olds
- 2,000 neonatal intensive care cots were recorded in the mapping and 1,317 cots in special care baby units. 21% of services rated their transfer arrangements between maternity and neonatal intensive care units as excellent and 57% as adequate
- Of the 25 PICU services mapped, all but 1 belonged to a managed clinical network for critically ill children. 12 of the services led the network
- 162 PCTs (68% of those responding to the relevant questionnaire) reported that they commissioned a paediatric continence programme.

1.6.4 Standard 8 - Disabled Children and Young People & Those with Complex Health Needs

- Universal and targeted services worked across the range of physical and learning disabilities, autistic spectrum disorders and sensory impairment to an almost equal degree. The only exception was children with complex needs which were exclusively cared for by specialist services for children with disabilities
- Less than half (48%) of disabled children's services had adopted a key worker system
- In services for children with disabilities and/or special needs 53% of providers reported that all their staff had received some level of disability training while 7% reported that none of their staff had undergone specific training
- 48% of disability services had developed extended nurse roles in disability (Fig. 1.6g)
- Only 11 disability services reported that they provided specifically for adolescents.

1.6.5 Standard 9 - the Mental Health and Psychological Well-being of Children and Young People

- Only data on tier 1 provision provided by non-specialist mental health providers was collected here. Tier 2 to 4 CAMHS services are mapped in a separate national exercise, the result of which can be explored at www.camhsmapping.org.uk.
- Mental health was identified as a focus of work by a broad range of universal and targeted services
- ADHD clinics were reported in only 61 of the 396 community paediatric services (15%) and the time spent on ADHD was usually less than 25%.

1.6.6 Standard 11 - Maternity Services

- Of the PCTs that responded, 88% reported that they had arrangements in place that enabled women to choose where they gave birth while 76% had arrangements in place for women to choose which health professional led their service. Only 29% of PCTs had a service level agreement that encompassed this choice
- Of the 160 maternity services, 141 (88%) had staff trained in delivering in a birthing pool but only 134 services (84%) had the facilities to offer this birthing option
- 78% of maternity services offered community based postnatal care
- The overwhelming majority of maternity services involved the mother's partners in antenatal education (90%).

Chapter 2:
Introduction

This chapter introduces the child health and maternity service mapping exercise and explains its process, method and content. The content of this report is outlined and important information on the reliability of the data presented. The chapter contains:

2.1 Overview

The national child health and maternity mapping exercise is the first attempt to build a profile of current health resources for children and young people that has been undertaken nationally and internationally. The mapping has established an annual process for the collection of service and finance data from primary care trusts and secondary and tertiary healthcare providers to establish an inventory of child health and maternity services. The mapping exercise was set up to support local service development and the monitoring of progress in the implementation of the National Service Framework for Children, Young People and Maternity Services (referred to in this document as the NSF). The exercise is expected to last for the life of this policy.

The project has been developed by the Department of Health and was formally announced by Dr Stephen Ladyman as part of the implementation programme for the children's NSF and Every Child Matters, commonly referred to as the Change for Children Programme. The exercise was launched in October 2005 and the data collection period ran from 1st November 2005 to 28th February 2006. This report summarises the findings of this first mapping exercise.

2.2 Background

The child health and maternity mapping exercise builds on the methodology developed for the mapping of adult, child and adolescent mental health services over a number of years. This web-based approach to national service and financial mapping lends itself well to capturing information needs expressed within children's health services and its ease of transfer into the child health field has been partly responsible for its rapid development.

The exercise began development in April 2004 following significant demand from local and national child health networks that were struggling to find ways to identify the starting point for services to measure their achievement against national standards.

Key stages in the development phase included:

- A review of relevant literature to learn about other relevant work that had been undertaken and to avoid duplication
- Structured interviews with key stakeholders to understand expectations and to define the desired scope of the exercise
- Definitional work with a national design group
- Development of the website, database and accompanying guidance
- Pilot testing with 10% of PCTs and their providers across England
- Evaluation of pilot site experiences and revision of the exercise
- Planning for national roll out with a communications strategy to keep partners informed of progress.

2.3 Project management

The project is managed through the Department of Health. A project lead, seconded from the field, developed the database in partnership with a National Design Group, which advised on definitional issues, and a National Steering Group, which ensured the support and input of professional organisations and government departments. The Durham Mapping Team based in the School of Applied Social Sciences at Durham University carried out the mapping. Their tasks included: designing and maintaining the website; delivering a training programme on the exercise; providing an email and telephone helpdesk to support data inputting; checking and analysing the results and preparing reports on the findings. In addition, the Mapping Team will be developing tools to increase the use of the mapping data for local and wider service development purposes.

2.4 Purpose and benefits

The primary purpose of the child health and maternity service mapping is to support the implementation of the child policy agenda, in particular the NSF[1]. Formally the mapping exercise is part of the Change for Children Programme and is set out in the national implementation plan, 'Supporting Local Delivery'[2].

The mapping has been designed to provide a number of additional benefits to those involved in the development of children's services. These include:

- To provide a baseline of current service provision at a time when health and social services are developing and implementing a radical change agenda for children
- To provide a common template across the country for an exercise needed to support the effective implementation of national policy
- To act as a diagnostic tool which will help identify key issues to be addressed and to monitor change over time
- To support benchmarking on the cost and nature of service provision
- To provide information needed by PCTs and by local authorities in the development of Children's Trusts and joint commissioning strategies in general
- To support the performance management agenda by making available information to the joint area review teams and by supplying measurable indicators within health
- To generate local service directories for the public and practitioners.

2.5 Mapping scope and content

The focus of the first year's data collection was on child health and maternity services but there is potential for the exercise to be extended more widely across children's services in the future and the methodology used has been designed with this in mind. A scoping study to explore the feasibility of this work has been commissioned and will report in autumn 2006.

Data from the mapping exercise are reported under four categories of service which have been further divided into 15 service types:

- **Universal services:**
  - Health visiting and early years health services
  - School health services

- **Targeted services:**
  - Paediatric therapy services
  - Other community paediatric services
  - Services for children with disabilities / special needs
  - Safeguarding children services
  - Services for children in special circumstances
  - Mental health services outside specialist CAMHS

- **Hospital services:**
  - Paediatric emergency services
  - General paediatric services
  - Paediatric surgery
  - Paediatric intensive care units
  - Specialised paediatric services
  - Neonatal intensive care units

- **Maternity services.**

Although the mapping focused on services for children and young people, service providers were not restricted to any particular age band for services. Instead, when describing each team/unit they were asked to specify the lower and upper age range accepted in the service. Commissioners, on the other hand, were asked to include only the funding of services for young people under the age of 19.

In accordance with policy, the mapping also covered the interface of child health services with other agencies such as the resources provided for extended schools, children's centres, children looked after and teenage pregnancy strategies.

2.6 Mapping process

At a request from the Department of Health, all PCTs and other NHS provider trusts delivering child health and/or maternity services nominated a lead manager to take responsibility for completion of the mapping exercise. Mapping leads were required to register on the mapping website so that they could receive a password that would enable access to secure data entry. They then build up a list of relevant services provided by their agency and co-ordinate data input, either entering the data themselves or delegating the task to others. Once the data had been entered, mapping leads were asked to check it and confirm its completion.

Different requirements were made of commissioners. They were asked a series of questions about planning and to report the child health and maternity service commissioning arrangements in the PCT. They were also asked to complete financial spreadsheets for each of the providing agencies that they commissioned.

Throughout the data collection period, the Durham Mapping Team provided support through a Helpdesk. This was very busy at times and valuable feedback was received which will be fed into the review of the mapping process and content in preparation for the 2006/7 exercise.

SHA children's leads have had a key supporting role throughout the process. They facilitated the regional training events in partnership with the mapping team and performance managed the completion of the data collection exercise through discussion with the PCTs and other NHS providers in their patch.

2.7 Outputs

The main outputs from the data collection exercise are as follows:

- Data reports summarising the information mapped. These have been made available in the form of tables that can be run on the website and downloaded as pdf files, Excel spreadsheets or maps. National and SHA level data is summarised in this report and available on the website. Data at regional and service level is available on the website only
- An inventory of children's health services that can be profiled by PCT, local authority and SHA. These form the basis of local service directories which are available on the website in list or map format
- As the mapping becomes more established, short topic reports will be produced. Data from this collection will be used to help develop web-based commissioners/planners work books in order to increase the tools that localities have to support them to interrogate and use the data.

2.8 The National Atlas

The national atlas is the first output from the mapping exercise. It represents a useful starting point for exploring the description of children's health and maternity services in England in 2006 presented in the mapping. The atlas reports at a national and SHA level only, setting out a picture of the commissioning and provision of child health services that is intended to support:

- policy makers to access national data on performance
- managers and clinicians within children's services to understand how services at SHA level stand against the national picture
- people new to the children's field to gain an overview of children's health services and the key issues facing them.

The atlas has five chapters set out as follows:

• **Chapter 1**	**Executive Summary and Key Messages**
• **Chapter 2**	**Introduction** giving a general overview of the mapping process and the report
• **Chapter 3**	**Planning, Commissioning and Finance** describing the overall planning and commissioning arrangements put in place and current spend on children's health and maternity services.
• **Chapter 4**	**A National Profile of Child Health and Maternity Services.** This is divided into 4 sections covering universal, targeted, hospital and maternity services.
• **Chapter 5**	**Progress against National Child and Maternity Health Policy.** This chapter reports progress against the national policy imperatives on which data has been collected in the mapping exercise. The chapter is divided into the themes of the NSF for ease of reference.

To facilitate the exploration of the data at a PCT or NHS trust level, the tables in the atlas can be run live on the website at www.childhealthmapping.org.uk/reports.
All tables have been given numbers corresponding to those in this report.

2.9 Accuracy and reliability

A great deal of careful work has gone into the production of the child health and maternity service mapping that is reported in this document. However, care must be taken in reading the data. A national mapping exercise of this nature is a very large undertaking – over 1,500 people contributed to the inputting of data and over 3,455 services have been described. Therefore the accuracy of the data must always be questioned. Also, this was the first year that such an exercise has been attempted in the child health and maternity field and as a result, the process itself was developmental and unfamiliar for those involved. It should be noted that the accuracy and reliability of data recorded in the other mapping exercises undertaken by the Durham Mapping Team has improved year on year as the process becomes more familiar and established. This is also expected of child health and maternity service mapping.

Three particular issues with the accuracy of the data in this report should be highlighted:

- The data returned is incomplete. Although the return rate was very high at over 95%, this meant that 8 PCTs and 30 other NHS provider trusts did not participate in the mapping and the number of missing services is not

known. Also, the detailed questions asked about each service mapped were not always answered in full. To take account of this, the response rate of each set of questions has been reported and, where relevant, percentages have been calculated to give the proportion of known services.

- In a data collection of this size in a developmental phase, there are always difficulties in interpreting definitions and questions. The Helpdesk became aware of different approaches being taken to some questions and were able to provide guidance but it is likely that those who did not contact the Helpdesk also varied in their approach. As it was a learning experience for everyone, even the guidance was altered as understanding of the issues deepened through the months of data collection.
- Services reported difficulties in disaggregating the information requested on specific types of questions. It was difficult to attribute staff time to particular service provision where staff worked across a number of services/units. It was also difficult to disaggregate the health contribution from services that were working towards, or had achieved, integration with other agencies. As only the health component of services was requested, elements of service/staff time had to be apportioned. The result was that estimates rather than hard data were input.

All these issues are being addressed in the review of the mapping and a thorough examination of definitions and guidance is being undertaken in preparation for next year's data collection round. On-line data checks are also being developed to alert those mapping of improbable and incomplete data.

2.10 Comments and questions

We are very keen to receive feedback on this atlas whether good, bad or indifferent! This is the first atlas of this kind, and we aim to improve it year on year in line with requests from the field. Please contact us by email or telephone as follows:

Email: help@childhealthmapping.org.uk

Telephone: 0191 334 1489

2.11 Next steps

The national child health and maternity service mapping exercise clearly only represents one part of the full service provision for children. It was always the intention of the exercise to test out a methodology in one sector before it was rolled out further. Our testing has demonstrated that the database is workable and the Department for Education and Skills (DFES) have agreed to a scoping study to explore possible extension of the mapping to include other aspects of children's services. In particularly, the scoping study is exploring the mapping of social care services for children and young people and support to pupils in education. This scoping study will report in autumn 2006.

The mapping service is working with the Healthcare Commission to ensure that a single process of data collection for performance purposes is used where possible.

Chapter 3:
Planning, Commissioning and Finance

This chapter reports the data provided by PCT commissioners. It is in three sections:

Mapping findings are reported only at national and strategic health authority levels within this report. Detailed tables and the full version of the report can be downloaded from the Child Mapping website at:

www.childhealthmapping.org.uk

3.1 Planning arrangements

3.1.1 Aim of the mapping exercise

This section of the mapping aims to provide an indication of the leadership and planning arrangements in place within PCTs. It was completed by commissioners to set the context within which the commissioning data could be examined.

3.1.2 Background

The importance of clear and dedicated leadership and management within all children's services has been a recurring theme in recent national inquiries. The report of the public inquiry into children's heart surgery at Bristol Royal Infirmary, known as the Kennedy Report[3], emphasised a lack of leadership and teamwork. It noted that very sick children were not a priority in Bristol or across the NHS and recommended that a National Director for Children's Healthcare in England should be established and national standards put in place.

The Victoria Climbié enquiry[4] highlighted the need for clear responsibility for children's issues at all levels, i.e. operationally, strategically and politically, stating that, 'While the standard of work done by those with direct contact with her was generally of very poor quality, the greatest failure rests with the managers and senior members of the authorities whose task it was to ensure that services for children like Victoria, were properly financed, staffed, and able to deliver good quality support to children and families'.

The Children Act 2004 has begun to address the issues raised by the Climbié enquiry, notably the appointment of a Minister for Children, lead council members for children's issues and directors of children's services in each local authority. In addition, local authorities must now establish clear multi-agency planning arrangements for children in relation to child protection and broader planning issues.

It is with this policy framework in mind that the child health and maternity service mapping attempts to articulate PCT leadership and management arrangements for children.

3.1.3 Leadership

PCT commissioners were asked to indicate whether their trust had a dedicated child health lead and whether the lead had managerial responsibility at board level. In the mapping, 240 PCTs (79%) completed the relevant questionnaire. Of those that responded, all but 2 PCTs reported having a children's lead. Of the leads, 57% of PCTs (136) had a dedicated lead, whose sole responsibility was children's health. In the remaining 43% of PCTs (103), the children's lead role was shared with another area of work (Table 3.1).

Considerable variation was apparent in the managerial level of children's leads. Of those PCTs with a lead, 41% (98 PCTs) reported a lead at director level, and 34% (82) had leads who were members of the trust board.

Table 3.1: PCT child health leadership

Strategic Health Authority	Number of PCT Commissioners	Completed Planning Arrangements Questionnaire	Proportion with Lead in place*	Proportion with Lead role share*	Proportion with Lead at director level not on board**	Proportion with Lead at director level on board**	Proportion with Lead other level*
Avon, Gloucestershire & Wiltshire	12	12	100%	25%	8%	-	67%
Bedfordshire and Hertfordshire	11	11	100%	82%	18%	55%	27%
Birmingham & the Black Country	12	9	100%	44%	22%	44%	33%
Cheshire and Merseyside	15	13	100%	8%	-	31%	46%
County Durham & Tees Valley	10	10	100%	50%	10%	50%	40%
Cumbria and Lancashire	13	10	100%	40%	-	60%	30%
Dorset and Somerset	9	9	100%	11%	-	33%	67%
Essex	13	13	100%	39%	8%	23%	69%
Greater Manchester	14	5	80%	25%	-	25%	75%
Hampshire and Isle of Wight	10	10	100%	60%	10%	20%	70%
Kent and Medway	9	7	100%	71%	-	29%	57%
Leicester, Northants & Rutland	9	6	100%	33%	-	17%	50%
Norfolk, Suffolk & Cambridgeshire	17	11	82%	44%	22%	22%	33%
N & E Yorkshire & N Lincolnshire	10	10	100%	50%	10%	40%	40%
North Central London	5	5	100%	60%	-	80%	20%
North East London	7	5	100%	60%	20%	-	60%
North West London	8	6	100%	83%	-	67%	33%
Northumberland, Tyne and Wear	6	6	100%	17%	-	33%	50%
Shropshire and Staffordshire	10	9	100%	22%	11%	67%	11%
South East London	6	6	100%	33%	33%	17%	50%
South West London	5	4	100%	25%	-	-	75%
South West Peninsula	11	11	100%	82%	-	27%	73%
South Yorkshire	9	2	100%	50%	-	-	100%
Surrey and Sussex	15	5	100%	80%	-	20%	60%
Thames Valley	15	9	100%	56%	11%	44%	44%
Trent	19	16	100%	38%	6%	50%	38%
West Midlands South	8	8	100%	25%	-	38%	50%
West Yorkshire	15	12	100%	17%	-	8%	75%
Total	**303**	**240**	**99%**	**43%**	**7%**	**34%**	**50%**

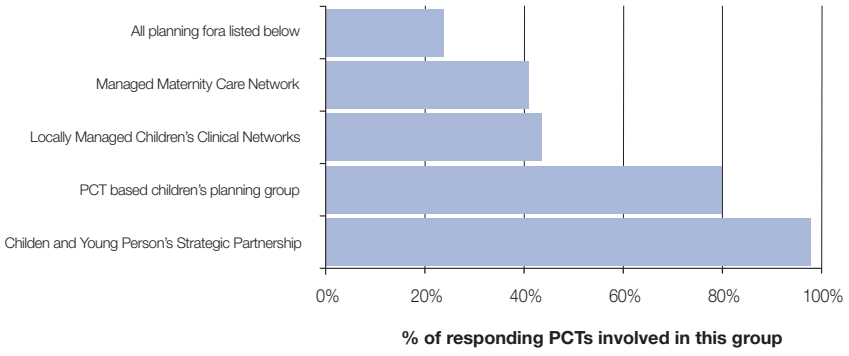
*Of those who have completed planning arrangements questionnaire.
**Of those who have a lead.

3.1.4 Involvement in planning fora

Within the planning questionnaire, commissioners were asked about the internal and external planning mechanisms that they were involved in and about attendance at clinical networks. A very high level of involvement in multi agency Children and Young People's Strategic Partnerships was found. Of the 240 responding PCTs, 98% of PCTs (235) actively contributed to a strategic partnership, indicating joint working with the local authority. At a single agency level, 81% of PCTs (192) reported involvement in PCT-based children's planning groups (Fig. 3.1a).

Involvement in clinical networks was less widespread with 44% of PCTs (106) reporting attendance at locally managed children's clinical networks and 41% of PCTs (98) reporting participation in managed maternity care networks. Involvement in all four types of planning groups was much less common, only 24% of PCTs (58), emphasising what appears to be a patchy participation in networks across the country. However, this may indicate that PCT leads shared this role with one lead representing a number of PCTs on a network.

Fig. 3.1a: PCT Involvement in different fora (N=240)

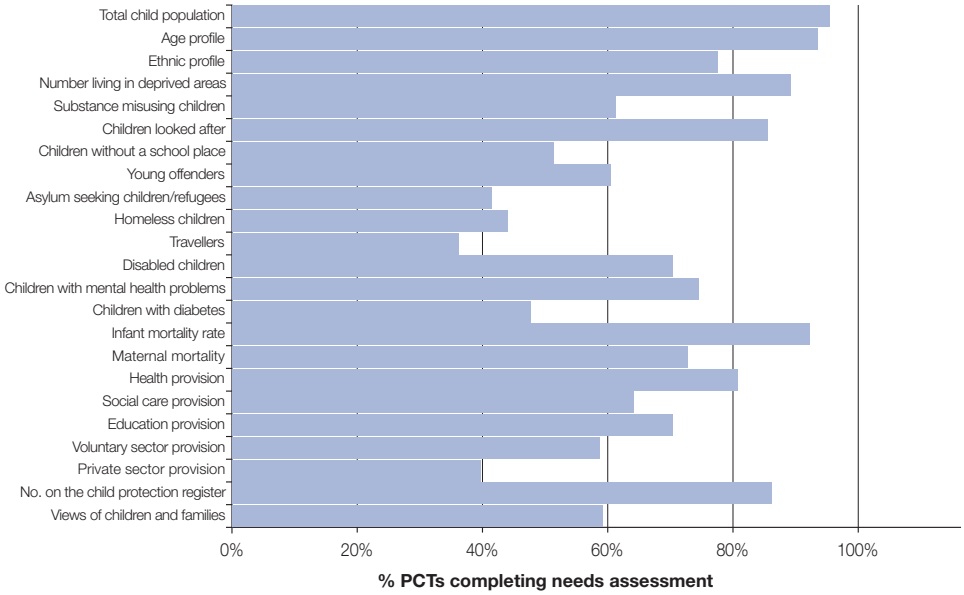


3.1.5 Completion of child health needs assessment

Commissioners were asked to indicate if they had completed a comprehensive child health needs assessment, and if so, what indicators of need had been considered. Overall, 164 PCTs had completed a needs assessment. This was 68% of PCTs that responded to the mapping questionnaire and 54% of all PCTs. In the assessments, demographic data was most likely to have been considered. For example, 95% of PCTs had assessed the child population size, 93% the age range of the population, 77% ethnicity and 89% aspects of deprivation (Fig. 3.1b).

The completion rate of the health needs assessment for specific groups of children and young people was more variable. The most commonly included groups were: looked-after children (85%) and children with mental health problems (74%) (although 95% of PCTs reported having an up to date CAMHS needs assessment in place in the local delivery plan returns in March 2006). Other groups of children and young people considered in the needs assessment were: disabled children (70%) and young offenders and substances users (61%). Much less common was the inclusion of children with diabetes (48%). Information on the number of children without a school place was included in 51% of assessments, and information on homeless children in 44% of assessments. Children of asylum seekers (41%) and travellers (36%) were the least likely groups to be considered, but this may reflect the patchy nature of need across the country.

Fig. 3.1b: Percentage of PCTs completing elements of a health needs assessment (N=164)



3.2 Commissioning

3.2.1 What was asked?

In this section of the mapping, PCT commissioners were asked to list the range of arrangements they had in place for the commissioning of dedicated children's health and maternity services. The aim was to develop an understanding not only of spend on child health and maternity services but also of the complex commissioning arrangements that have been set up to manage the expenditure.

For the purpose of this mapping exercise, commissioning was described as the range of service level agreements in place between PCTs and providers. This included:

- single commissioning arrangements between one PCT and a NHS provider
- joint commissioning arrangements with local authorities
- specialist commissioning arrangements involving other PCTs
- spot purchasing.

3.2.2 Background

The NHS is in the midst of significant reconfiguration as it implements the key aspects of 'Commissioning a patient-led NHS'[5]. This includes the development of practice based commissioning, SHA and PCT mergers and the full-scale development of Foundation Trusts across England. Allied to this, within children's services, is the way in which the commissioning of services is being influenced by the requirement of the Children Act 2004 to develop children's trusts by 2008 in each local authority.

As part of the mapping process we aimed to describe the current commissioning arrangements before these major changes take place. The methodology used will allow us to map the changes to the commissioning arrangements for children on an annual basis as current policies are implemented.

3.2.3 Commissioning arrangements

Findings from the mapping should only be taken as an indication of the different commissioning arrangements that were in place as commissioners found it difficult to express the complexities of commissioning in the format required by the mapping web site. A particular challenge was to ensure there was no double counting where PCTs commissioned in a group or consortium arrangement. Only the lead commissioner was expected to complete the mapping but there were often difficulties in apportioning budgets between PCTs in the group. Consequently caution should be used when reading the data.

The findings show that in 2004/5 the majority of child health services were commissioned through single PCT commissioning arrangements (Fig. 3.2a). This accounted for 79% of the reported child health budget. Relatively little joint commissioning was reported with only 14% of the budget used in this way. Specialist commissioning of regional and sub-regional specialties accounted for 5% of the budget. Spot commissioning accounted for only 2% but PCTs were anxious to record it. Spot purchasing was usually for the support of individual children with complex needs and, although a small proportion of the overall budget, this expenditure could have a serious impact on moneys earmarked for service development.

Considerable differences in commissioning arrangements were apparent around the country (Figs. 3.2b and Table 3.2) due partly to historical differences in the development of commissioning in some localities, especially with regard to specialist services. It is expected that this picture will change considerably over the next few years as a result of PCT & SHA reorganisation and new commissioning approaches being introduced by the Department of Health.

Fig. 3.2a: 2004/5 budget by commissioning type

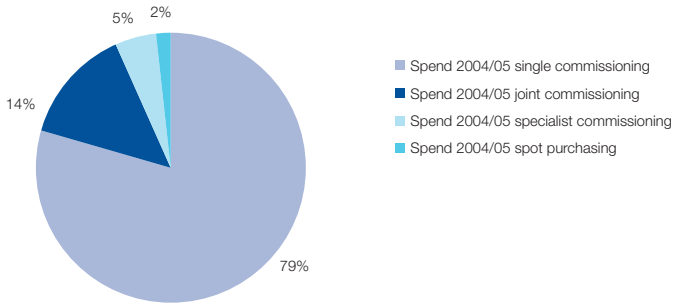


Fig. 3.2b: Commissioning arrangements 2004/5 within PCTs by size of spend by strategic health authority

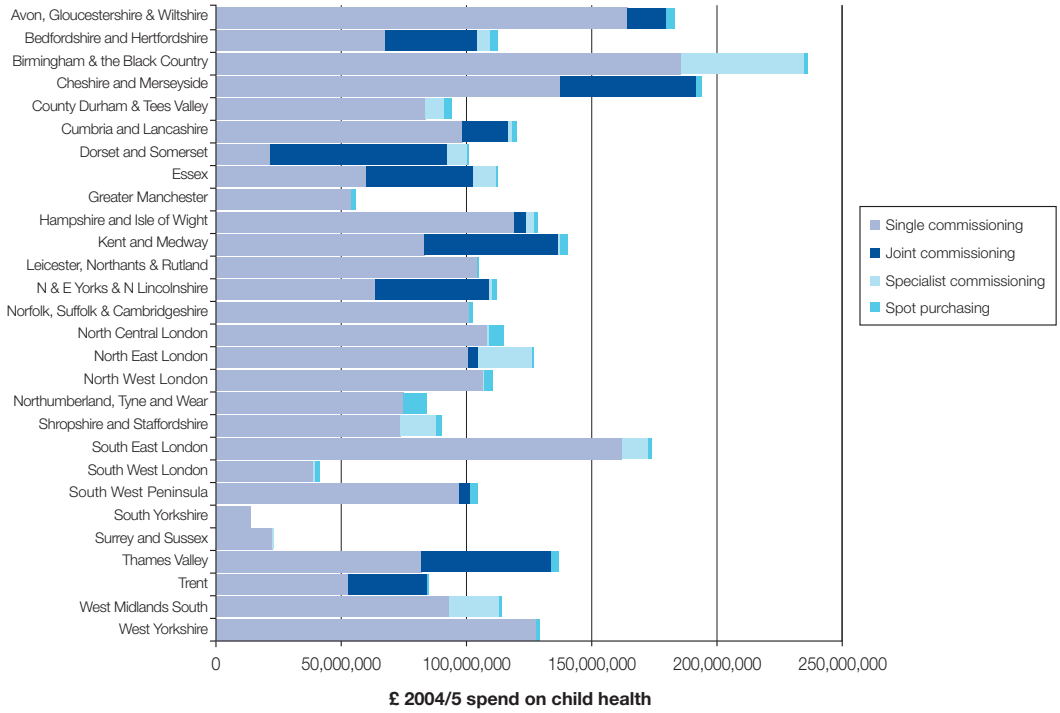


Table 3.2: 2004/5 budget by commissioning type

Strategic Health Authority	Single Commissioning £k	Joint Commissioning £k	Specialist Commissioning £k	Spot Purchasing* £k	2004/05 Total £k**	PCT completed sign off
Avon, Gloucestershire & Wiltshire	163,963	15,670	-	3,072	182,704	100%
Bedfordshire and Hertfordshire	67,530	36,751	5,309	2,503	112,094	91%
Birmingham & the Black Country	185,371	-	49,200	1,551	236,122	75%
Cheshire and Merseyside	137,254	54,066	-	2,238	193,559	60%
County Durham & Tees Valley	83,423	-	8,042	2,673	94,138	80%
Cumbria and Lancashire	98,086	18,476	1,814	1,843	120,220	69%
Dorset and Somerset	21,944	70,604	7,350	816	100,714	89%
Essex	59,926	42,590	9,221	695	112,432	85%
Greater Manchester	53,995	-	-	1,938	55,933	14%
Hampshire and Isle of Wight	118,645	5,147	3,360	1,156	128,308	50%
Kent and Medway	82,798	53,587	392	2,951	139,728	89%
Leicester, Northants & Rutland	103,977	-	-	534	104,511	78%
Norfolk, Suffolk & Cambridgeshire	63,403	45,266	1,196	1,933	111,799	90%
N & E Yorkshire & N Lincolnshire	101,351	-	-	1,117	102,468	47%
North Central London	108,236	-	654	5,620	114,510	80%
North East London	100,665	3,759	21,546	645	126,615	29%
North West London	106,367	120	309	3,671	110,467	63%
Northumberland, Tyne and Wear	74,564	-	9,312	498	84,374	83%
Shropshire and Staffordshire	73,427	-	14,314	2,188	89,929	60%
South East London	161,503	-	10,652	1,153	173,308	67%
South West London	38,991	-	271	1,828	41,090	20%
South West Peninsula	97,155	4,295	-	2,861	104,312	91%
South Yorkshire	13,686	-	-	-	13,686	-
Surrey and Sussex	22,249	-	467	-	22,710	7%
Thames Valley	81,839	51,609	-	3,282	136,730	40%
Trent	52,909	31,033	-	662	84,604	63%
West Midlands South	92,954	35	19,744	1,200	113,933	63%
West Yorkshire	127,769	-	-	1,083	128,852	60%
Total	**2,493,975**	**433,009**	**163,155**	**49,712**	**3,139,852**	

*Including risk-sharing contributions
**Including maternity and spot purchasing

3.3 Finance

3.3.1 Aim of the mapping

The aim of this section of the mapping was:

- To collect information on the annual national spend on dedicated children's health and maternity services, identifying expenditure on particular categories of service
- To begin to develop knowledge of trends in expenditure on children's health and maternity services for the two financial years 2004/5 and 2005/6 to enable the first indications of annual changes in investment to be calculated.

Data was collected at PCT level but it has been aggregated to SHAs for the purpose of this report. Service types have also been aggregated into the four broad service categories; universal, targeted, hospital and maternity.

3.3.2 Background

Some of the challenges of separating out data on child health spend include:

- Difficulties in separating out children's services from generic all age services as hospital contracts rarely specify the child specific elements within service level agreements between PCTs and acute service providers
- Difficulties in identifying child health services as they are often complex and many different professionals and agencies may contribute to the care of a child. Therefore it is necessary to break services down into their constituent parts before the resources involved can be identified
- Although initiatives such as payment by results should begin to address the use of resources in much more detail, this initiative will relate only to hospital based children's services in the first phase of implementation.

Our pilot study revealed that this part of the child health and maternity service mapping was the most challenging section to complete, but also the most potentially useful output of the exercise. Locally, sites felt that they would value the data to support business cases for service development. At a national level, the data should support broader spending reviews conducted by the Treasury.

3.3.3 What was asked?

PCT commissioners were asked to complete a financial spreadsheet for each NHS provider with whom they had a service level agreement for the provision of children's health services. The requirement was to provide the expected spend for the current financial year (2005/6) and the actual spend for the previous year (2004/5). Spend was then further divided into the 15 services types being mapped by provider. Expenditure figures for both years were requested so that the two annual figures could be compared to give an indication of trends. This approach also ensures that the data for the two given years is based on the same assumptions. As some estimates and apportionment of data is likely in the mapping, this is an important safeguard for the reliability of reported data.

Spend included staff costs, non-staff costs and a proportion of overhead costs. Capital costs were excluded. In recognition of the difficulties of the task, commissioners were asked to estimate budgets where it was not possible to disaggregate PCT data within the time available but to indicate where estimates were being provided. It is hoped that reliance on estimates will reduce as familiarity with the mapping process develops and PCTs set up systems to collect the required data. The feasibility of removing the estimate option will be reviewed on an annual basis.

3.3.4 The results

As it is crucial that the difficulties involved in collecting the finance data in the first year of mapping are appreciated, a table of data quality has been generated (Annex 2). This shows that from 303 PCTs, 290 commissioners registered for the mapping exercise to complete finance section. In order to complete certain data, some commissioners delegated particular spreadsheets to their colleagues. As a result, a total of 326 NHS staff were engaged in the exercise. Altogether they generated 1,608 finance spreadsheets. This represents a great deal of work on behalf of the commissioners concerned.

Of the 286 registered commissioners, 269 provided finance data, giving a response rate of 89% of all PCTs. However, there was a high rate of incompletion with only 185 commissioners (66% of all PCTs) 'signing off' the exercise to confirm it was complete. It should also be noted that 60% of spreadsheets included estimated data.

During the mapping, commissioners raised a number of finance related issues, including:

- Service level agreements rarely defined services in the categories required in the service mapping and therefore it was very difficult to disaggregate expenditure under these headings
- PCTs with joint management strategies or consortia arrangements found it difficult to apportion spend between PCTs
- Commissioners reported being aware of differences in interpretation being used by neighbouring PCTs.

3.3.5 Reported spend

Total reported spend on child health and maternity services in 2004/5 was £3,140M. As this was submitted by 269 PCTs, 89% of all PCT commissioners, this is likely to be an underestimate. If 100% of PCTs had reported spend at the same rate, the total figures could have been over £3,500M.

Out of a total reported spend of £3,140M in 2004/5, £1,243M (39%) was spent on hospital services, £933M (30%) on maternity services, £472M (15%) on universal services and £443M (14%) on targeted services (Fig. 3.3a). Spot purchasing accounted for an additional £50M (2%).

Fig. 3.3a: Reported 2004/5 child health and maternity service spend by service category

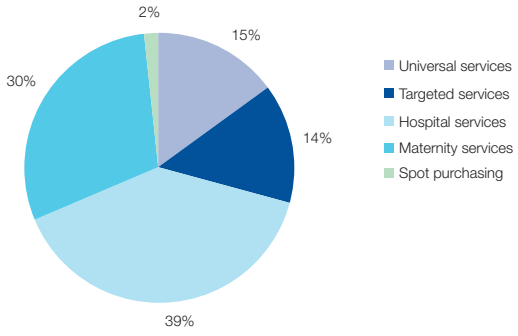
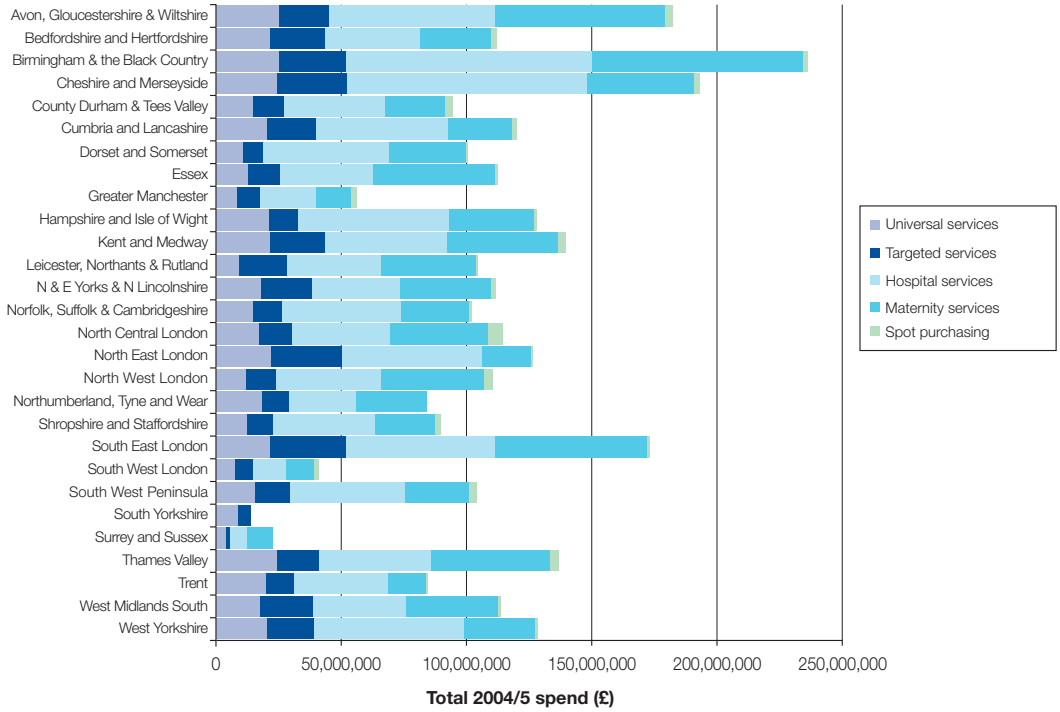
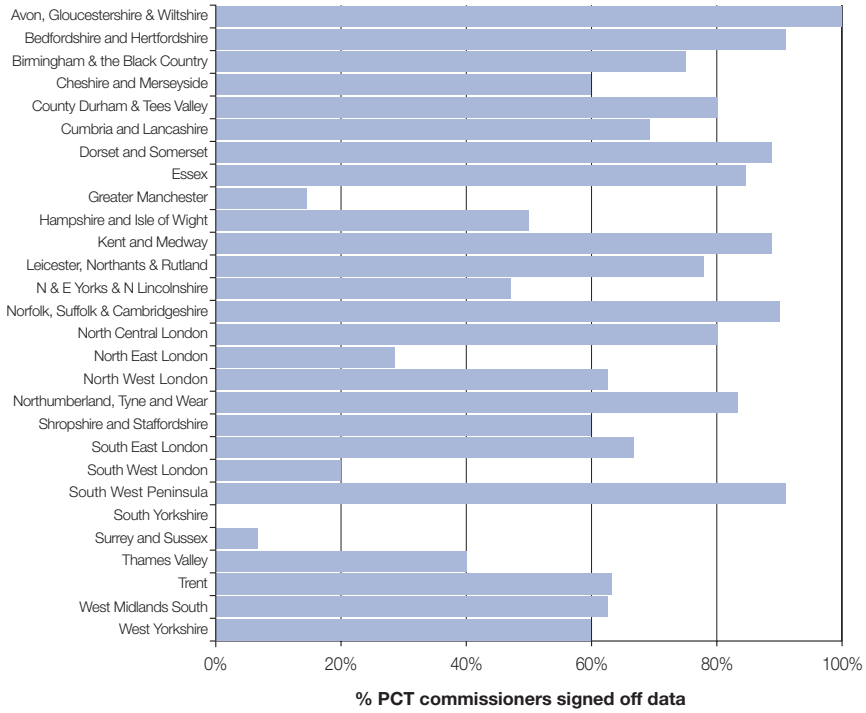


Fig. 3.3b: 2004/5 reported spend by SHA and service category



Reported spend varied widely by SHA but this was strongly affected by variable response rates and caution should be used in examining the data. For example, low spend may indicate a low number of completed spreadsheets being submitted rather than low spend on children's health services (see Fig. 3.3b). To enable a comparison with response rates, Fig. 3.3c is provided showing the proportion of PCTs within each SHA that signed off their finance mapping submissions.

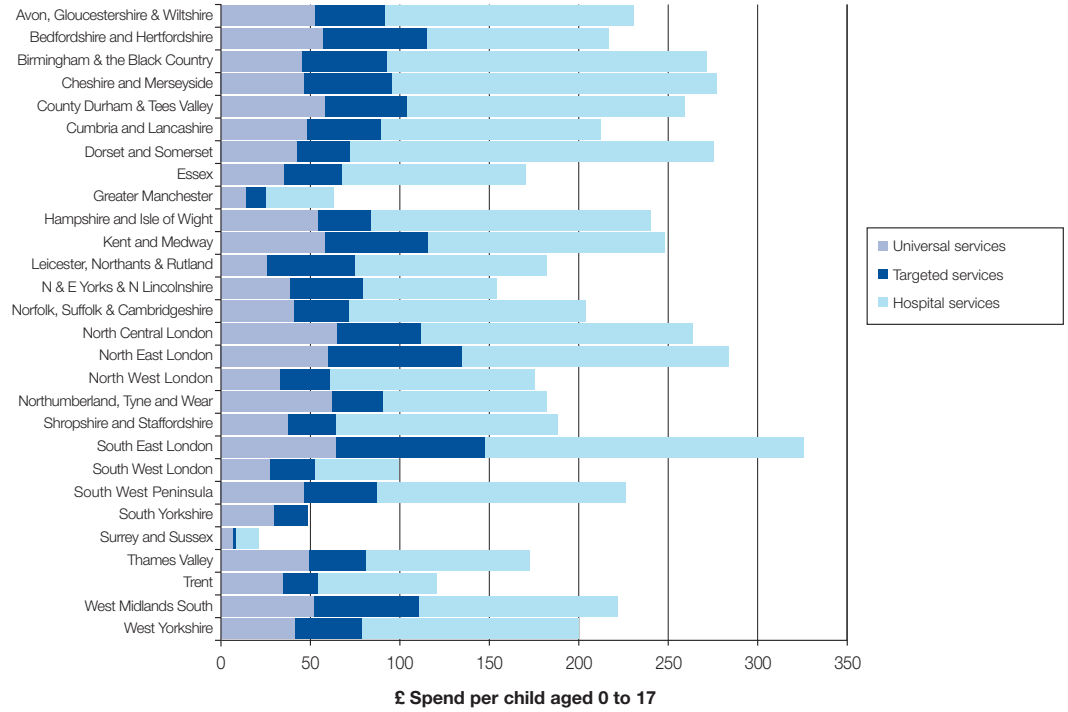
Fig. 3.3c: Rates of sign off on commisioning data - the proportion of PCTs within an SHA that signed off finance mapping submissions



3.3.6 Spend per child

Reported expenditure for the financial year 2004/5 gives a national spend on child health services of £195 per child aged 0 to 17. Spend on universal services was £43, on targeted services £38 and on hospital services £112. Again these spend figures will be an underestimate owing to the incomplete nature of the finance data but they provide useful comparisons on how child health expenditure is apportioned between its elements within SHAs (Fig. 3.3d). To check on data quality, Fig. 3.3d should be compared to Fig. 3.3c which provides information on commissioner response rates and indicates where the missing data is likely to be.

Fig. 3.3d: 2004/5 spend per child aged 0 to 17 on universal, targeted and hospital child health services



3.3.7 Spend on maternity services

In the mapping exercise, total spend reported on maternity services was £933M, giving a national cost per birth of £2,186 in 2004/5. This makes an interesting comparison with spend per child. However, this figure must be treated with caution as the data has two different sources. The number of births was submitted by service providers, whilst the expenditure on services was submitted by PCTs. Further checks are needed to ensure data were not distorted by incomplete submissions.

3.4 Change in spend on child health and maternity care

Owing to the data quality concerns discussed above, the expected change in spend on child health and maternity services should be treated as an indicative table only (Table 3.4). It summarises the changes expected between the 2004/5 actual spend on child health and maternity services and the projected spend on the same services in 2005/6. As both these budget figures were requested in a single submission, it was hoped the same calculations would be made for each year.

Indications of the change in budgets mapped provide a positive picture. It suggests that spend on universal services will increase by 6%, targeted services by 7%, hospital services by 11%, and maternity services by 7%. Considerable local variation was evident pointing to local difficulties in maintaining spend on child health services. As this data builds up year on year, it will be interesting to observe the trends.

Table 3.4: Trends in spend by category

Strategic Health Authority	Universal services change 2004/2005 to 2005/06	Targeted services change 2004/2005 to 2005/06	Hospital services change 2004/2005 to 2005/06	Maternity services change 2004/2005 to 2005/06
Avon, Gloucestershire & Wiltshire	4%	6%	9%	3%
Bedfordshire and Hertfordshire	4%	7%	7%	5%
Birmingham & the Black Country	-5%	10%	14%	4%
Cheshire and Merseyside	4%	10%	8%	9%
County Durham & Tees Valley	9%	3%	12%	1%
Cumbria and Lancashire	10%	6%	1%	4%
Dorset and Somerset	8%	7%	3%	3%
Essex	12%	10%	14%	5%
Greater Manchester	4%	19%	29%	12%
Hampshire and Isle of Wight	1%	4%	4%	-1%
Kent and Medway	7%	9%	7%	8%
Leicester, Northants & Rutland	-8%	-23%	1%	9%
Norfolk, Suffolk & Cambridgeshire	4%	9%	13%	-7%
N & E Yorkshire & N Lincolnshire	5%	7%	-1%	33%
North Central London	7%	12%	25%	-25%
North East London	5%	4%	-4%	39%
North West London	8%	28%	17%	5%
Northumberland, Tyne and Wear	-1%	7%	13%	21%
Shropshire and Staffordshire	5%	16%	-1%	15%
South East London	28%	6%	1%	3%
South West London	3%	2%	38%	95%
South West Peninsula	7%	15%	9%	4%
South Yorkshire	5%	5%	-	-
Surrey and Sussex	5%	6%	13%	4%
Thames Valley	-3%	7%	4%	9%
Trent	15%	8%	7%	20%
West Midlands South	3%	6%	6%	6%
West Yorkshire	11%	7%	79%	12%
Total	**6%**	**7%**	**11%**	**7%**

Chapter 4:
A National Profile of Children's Health and Maternity Services

The aim of this chapter is to report the child health and maternity services that have been mapped in order to build up a national profile of service provision. The chapter is divided into four sections based on the four main groups of service:

For ease of reading, each section is structured in the same way. The description provides information on the scope of provision, service characteristics, the focus of work, staffing and observations from the field. The chapter ends with a report of the use of IT facilities that looks at both the availability of IT functions and its usage by the teams mapped.

Mapping findings are reported only at national and strategic health authority levels within this report. Detailed tables showing commissioner and provider trust reports can be downloaded from the Child Mapping website at:

www.childhealthmapping.org.uk/reports

The online tables offer the facility of 'drilling down' by clicking on service names to investigate the detailed information mapped for services.

4.1 Universal Services

Service definitions

Early Years and Health Visiting Services

There are two aspects to these services as the name suggests. Early years services refer to multi disciplinary teams delivering a family centred public health role to pre-school children and their families. Health visiting services deliver a similar role to children, young people and their families, but primarily through a single health professional type. In many cases these services will be one and the same but named and configured differently by PCTs. The role of both is to improve health and to tackle inequalities.

School Health Services

School health services refer to staff, mainly school nurses, community doctors and support workers, working in a team or network to offer a needs based approach to the provision of healthcare within schools for children and young people aged 4 to 18. School nurses have a public health role with school-aged children, their families, schools and the surrounding communities to promote health, carry out school-based activities and to work with partners to address health inequalities.

4.1.1 Introduction

Universal services are so called because they are available to the whole child population. Two specific types of service were mapped:

- Early Years and Health Visiting
- School Health Services.

This section is closely linked to standard 1 of the NSF which is concerned with promoting health and well-being, identifying needs and intervening early. Essentially, early years and health visiting services and school health services can be considered to be prevention and early intervention services although they have responsibilities to deliver other core NSF standards, such as safeguarding the welfare of children and young people or supporting children with disabilities and/or special needs.

Broad information about the nature and scope of the services mapped is provided here. Further information on the impact of key child health policy issues on these services is provided in chapter 5.

4.1.2 Service provision

Universal services tended to be provided by PCTs and mapped as teams serving a whole PCT area. There were some exceptions to this. First, a small number of services were provided by other NHS trusts and secondly, some PCTs chose to map their services differently. They did not record their universal services as single PCT-wide team but mapped a number of teams serving the PCT area. Overall, 248 of the 303 PCTs in England mapped universal services – 82% of all PCTs.

A total of 484 early years and health visiting services and 323 school health services were reported. However, it should be noted that not all services provided a broad range of functions.

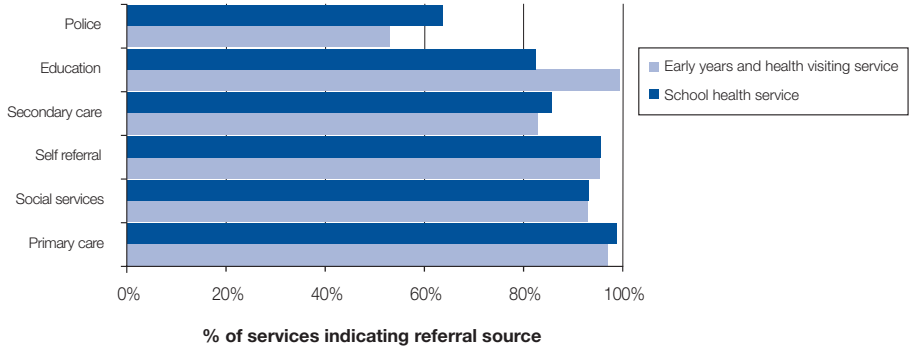
4.1.3 Age range

As might be expected given the broad remit of health visitors, the age range of people supported by early years and health visiting services spanned from cradle to grave. Wide variation was reported across the country but the common starting point for the services was birth. School health services spanned the years that children and young people spend in primary and secondary education and recorded a minimum age of 4 and upper age of 19.

4.1.4 Universal services referral sources

Early years and health visiting and school health services indicated a broad range of referral sources (Fig. 4.1a). Almost all services reported receiving referrals from primary care and over 90% of services referrals through self referral and social services. 85% of early years and health visiting services and 83% of school health services received referrals from secondary care. Education was a source of referral for all school health services and for 82% of early years and health visiting services. The police were a referral source for more early years and health visiting services (63%) than for school health services (53%).

Fig. 4.1a: Source of referrals to universal services.



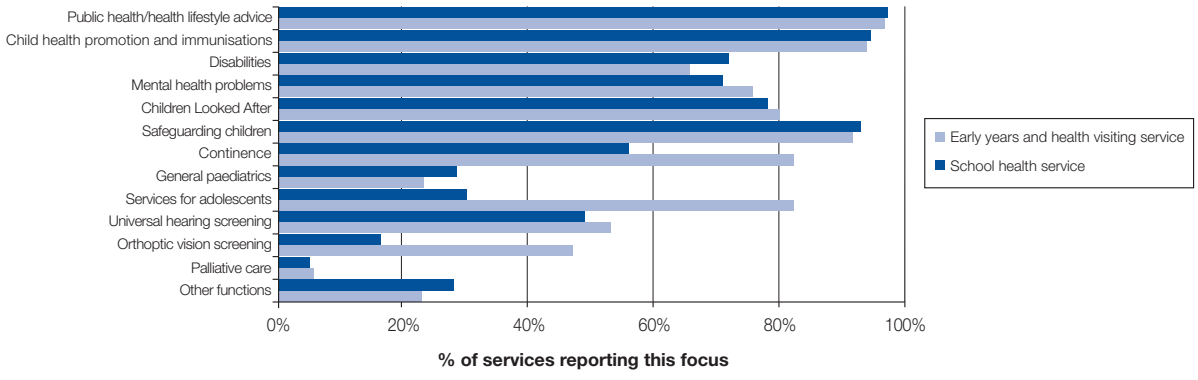
4.1.5 Focus of work

The principal foci of the work of universal services were public health, lifestyle advice, health promotion, immunisation and safeguarding children. Over 90% of all universal services indicated that they provided these functions, which suggested some uniformity across the country (Fig. 4.1b). Services without these main foci tended to be dedicated single focus services such as immunisation teams or hearing screening services.

Other foci which were important across both universal services were:

- The provision of support for looked-after children (78% of early years and health visiting services and 80% of school health services)
- Supporting children with disabilities (72% of early years and health visiting and 66% of school health services)
- Supporting children and/or mothers with mental health problems (71% of early years and health visiting and 76% of school health services)
- Continence support for children with enuresis/encoprisis was provided by 56% of early years and health visiting services and support for children with enduring incontinence problems was provided 82% of school health services.

Fig. 4.1b: Focus of work of universal services



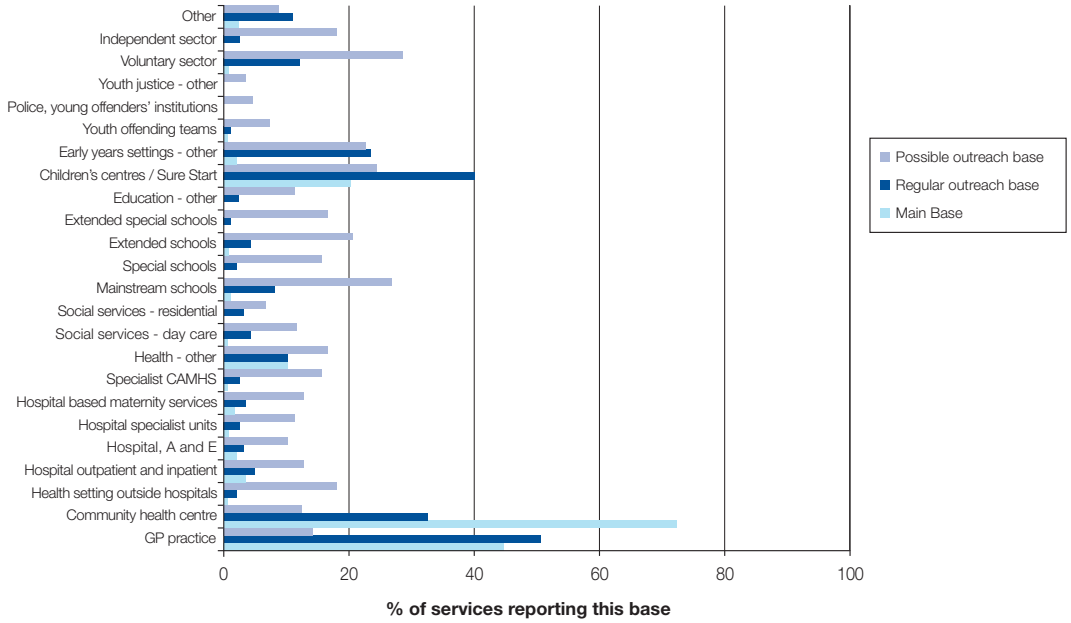
4.1.6 Work settings

An important characteristic of a service is the setting in which staff work as this provides an indication of the service's accessibility. In the mapping, services were asked to identify the settings used, indicating whether the setting was a main base or a regular location for outreach work. They were also asked to identify possible outreach settings that they may use in the future.

Fig. 4.1c illustrates the main base and outreach settings that were mapped for early years and health visiting services. The dominance of main bases located in community health centres (72% of services) and GP practices (45% of services) might be expected but it was interesting that services had bases in a range of other health settings, a number of schools and as many as 20% of services were based in Sure Start and Children's Development Centres.

Outreach work reinforced the importance of primary care and community health settings. In addition, 40% of services provided outreach into Sure Start and children's centres and 24% into other early years services. 29% of services provided outreach in voluntary sector settings. Few services indicated that they currently worked in education or youth offending settings but these were identified as possible outreach settings in the future. Over 20% of services indicated that they could be working in mainstream and extended mainstream schools in the future and 15% suggested special schools and extended special schools as possible future bases. These figures suggest that the NHS has been responsive to the Government's early years and children's centre strategy and there is already a solid base from which to develop.

Fig. 4.1c: Settings of early years and health visiting services

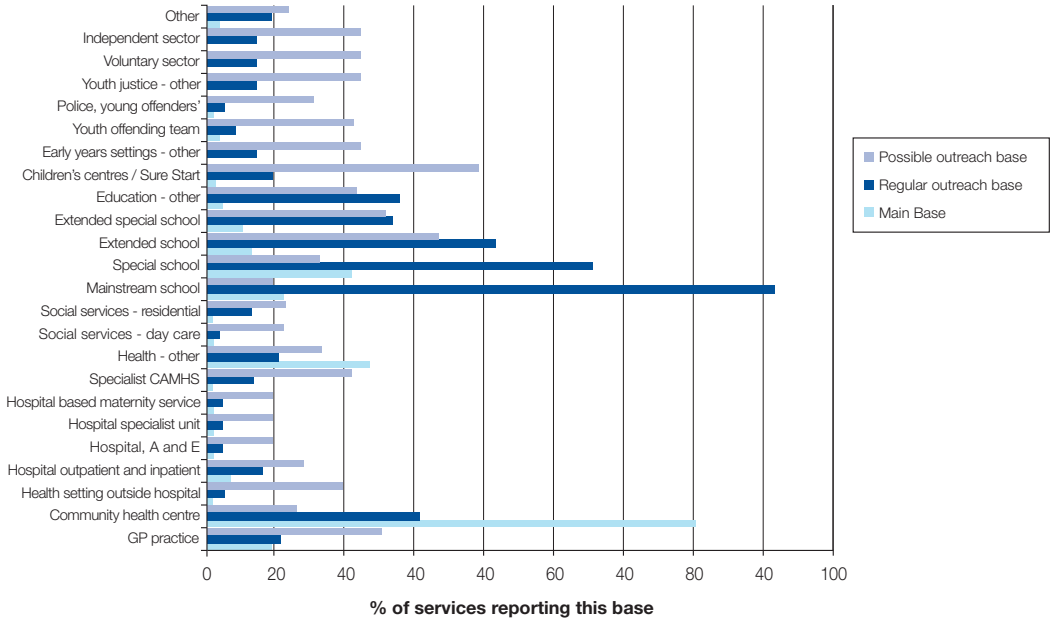


The majority (70%) of school health services were based in community health centres. Main base locations in schools were less common with just 11% of school health services having a main base in mainstream schools, 21% in special schools, 6% in extended mainstream schools and 5% in extended special schools (Fig. 4.1d).

Work in schools tended to be outreach. 82% of school health services outreached into mainstream schools, 55% into special schools, 42% into extended mainstream schools and 27% into extended special schools. The settings for possible future work indicated further broadening of access to child health services with increased

activity in youth offending services, Sure Start, early years and family centres and services in the voluntary and private sectors. Figures suggest that local health services are beginning to respond to the Government's policy on extended schools and this may be an area where greater activity is seen in the future.

Fig. 4.1d: School health service settings in education, social services, youth justice and the independent sector.



4.1.7 Universal services workforce

In universal services, providers mapped a workforce totalling 14,507 WTE. Nursing staff accounted for 70% of the universal service workforce, followed by 16% unqualified staff and 12% administrative staff (Table 4.1a). In total, 66 WTE medical staff were recorded -13 WTE in early years and health visiting services and 53 WTE in school health services. 120 WTE therapists and 27 WTE midwives were reported in universal services.

The make up of the workforce of early years and health visiting services was very similar to that of school health services. The total workforce of early years and health visiting services was around 11,000 WTE, an average of 22 WTE per team/service (Table 4.1). School health services had considerably smaller staff teams. Their total workforce was around 3,550 WTE, an average of 10 WTE staff per team/service. However, only a minority of localities met the policy standard of 1 WTE school nurse per school cluster. This is discussed in more detail in section 5.2.6.

Vacancy rates across universal services averaged 9.4% but this masked the higher vacancy rate of 15.4% in school health services compared to 7.3% in early years and health visiting services.

Table 4.1a: Staffing in universal services (WTE)

Service Type	Early years and health visiting service	School health service	Total
Medical staff	13	53	66
Nursing staff	7,753	2,453	10,205
Therapy staff	82	38	120
Midwifery staff	27	-	27
Non-qualified staff	1,906	449	2,355
Admin staff	1,148	531	1,679
Other staff	40	13	53
Total staff	**10,970**	**3,537**	**14,507**
Total funded vacancies	861.2	644.5	1,505.7
Total establishment	11,831.2	4,181.8	16,013.0
Vacancy rate	7.3%	15.4%	9.4%

4.1.8 Feedback from the field

It was particularly helpful to receive comments from the field about how the mapping could be improved in this fast developing area of work. On early years and health visiting services, comments tended to focus on Sure Start and child development centres and the nature of health visiting. Requests were made for developments in the mapping framework to ensure greater recognition of:

- The integrated nature of staff teams and ways of working
- The growing role of children's centres in the delivery of child centred services
- The need to include social workers in health staff teams
- The broader role of many health visitors in supporting adults.

Comments on school health services focused on school nurses, health promotion and public health responsibilities. An improved definition of a School Nurse was requested. Better ways of capturing school nurses working on a contractual basis in independent or private schools was also requested. Other comments related to the work undertaken by school health services, in particular the need to distinguish public health from other functions. There was a call to identify public health practitioners and health promotion staff separately, and even to add public health services to the list of universal services mapped.

4.2 Targeted Services

Definitions

Safeguarding children services

Safeguarding services refer to teams/staff specifically established to respond to child protection issues. A typical service would provide advice and support to a range of professionals and organisations and may respond to requests for clinical examinations. This includes only the dedicated time of staff employed to deliver this service such as designated doctors and nurses and the input of named doctors and nurses. This does not include the implicit duty of all child health professionals to adhere to safeguarding children responsibilities.

Paediatric therapy services

Paediatric therapy services are made up of allied health professionals and other therapists whose primary identity is to their professional grouping rather than any other service that they may be formally integrated with. In addition to delivering interventions within their own service, staff from paediatric therapy services usually work within a number of multi-disciplinary teams, in, for example, child development centres, disability services or special diagnosis services.

Other paediatric services provided in the community

This service type refers to community based teams providing for a range of second level care paediatric issues in non-acute settings. Services can respond to issues such as children's public health, work with disabilities, mental health issues and community based palliative care. Service might also input to children's centres and Health Action Zones. Both staff who work exclusively within this service as well as the sessional input of staff from other service types should be included.

Services for children with a disability/special needs

This service type refers to separately established services whose primary function is to provide support to children with a long term or life-threatening disability or condition. This includes: learning disabilities; physical disabilities; sensory impairment; complex health needs and autistic spectrum disorder. Staff may work solely within this service but the service is also likely to receive sessional input of staff from other types of service.

Services for children in special circumstances

This service type refers to separately established services whose primary function is to support children considered to have a specific need and to be regarded as being at risk of health problems due to their situation. This includes: services for homeless children, substance misusing children, teenage parents, children looked after, children with blood borne illnesses, asylum seekers and travellers. Both staff who work exclusively within this service as well as the sessional input of staff from other service types should be included.

Mental health services outside specialist CAMHS

These are separately established tier 1 mental health services that are not mapped as part of the National CAMHS mapping exercise which captures specialist tier 2-4 services. Tier 1 services are most likely to be provided by PCTs and the voluntary sector and examples include, counselling services, services for children with ADHD and services for children who have been abused. Staff may work solely within this team and teams may benefit from the sessional input of staff from other types of service. General mental health activities delivered by most universal and targeted children's health services should not be included, nor should mental health services delivered by other types of service, such as, ADHD clinics provided in community paediatric service. Separately established and funded ADHD services should be included.

4.2.1 Introduction

For the purpose of this exercise, targeted services are services for children who are vulnerable or have special needs. They are second level services, offered to children who could benefit from specialist input, usually after referral.

The six types of targeted services mapped are listed below with the corresponding standard in the NSF given in brackets where a standard directly applies:

- Safeguarding children services (standard 5)
- Paediatric therapy services
- Other paediatric services provided in the community
- Services for children with disabilities (standard 8)
- Services for children in special circumstances
- Mental health services outside specialist child health and adolescent mental health services (CAMHS) (standard 9).

The main difficulty arising from the targeted service types defined above was the considerable crossover of functions and staff between service types and services on the ground. Few members of staff worked exclusively in a single targeted service as defined. It was more common that they worked in a number of services providing sessional input in each in order to create teams of professional support around the individual needs of children and young people. Therefore allocating staff time between services was a challenge that generated considerable traffic on the Helpdesk as solutions were sought to enable the mapping to be completed for the first time.

The description of targeted services provided here gives broad information about the nature and extent of services across England. Information relating to specific key policy issues is covered in Chapter 5.

Fig. 4.2a: Number of targeted services mapped (N=1,748)

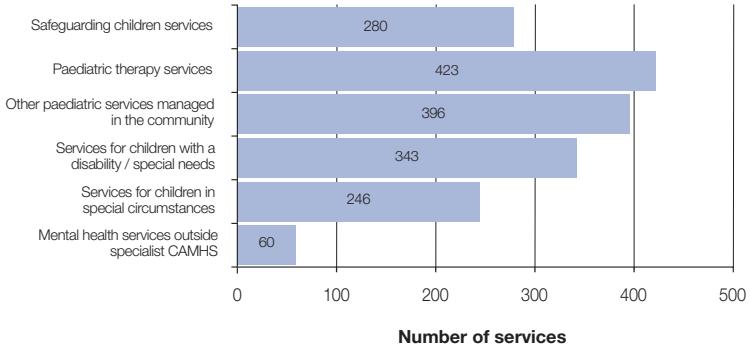
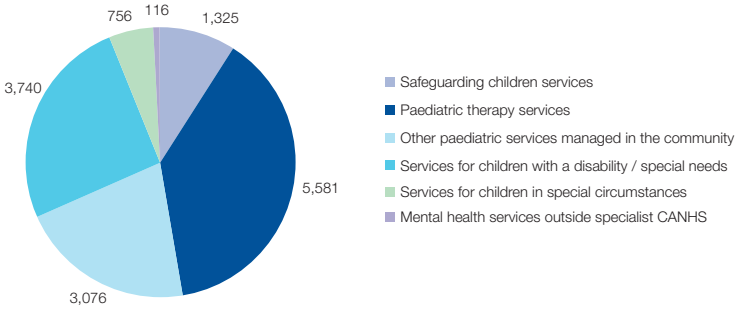


Fig. 4.2b: Targeted services workforce by service type (Number of WTE staff)



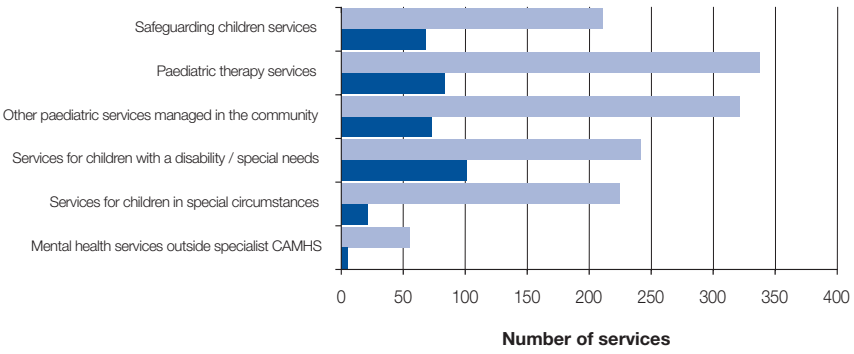
4.2.2 Service provision

Overall, 1,748 targeted services were identified in the 2005/6 mapping exercise. Of these, 24% (423 services) were paediatric therapy services which employed 38% of the targeted service workforce (Fig. 4.2 a and b). The next largest service type was other paediatric services managed in the community. These made up 23% of targeted services (396 services) and employed 21% of the targeted service workforce. 20% (343 services) of targeted services were services for children with disabilities and special needs and 14% (246 services) were services for children in special circumstances. These employed 26% and 5% of the targeted service workforce respectively.

Safeguarding children services also showed a relatively small staff resource. There were 280 services (16% of all targeted services) employing 9% of the targeted team workforce. Only 60 mental health services provided outside specialist CAMHS were mapped (3% of targeted services) employing 1% of targeted team staffing.

The majority of targeted services (80%) were provided by PCTs but it is not possible to deduce from the current mapping which services were provided by one PCT on behalf of another. Over 90% of services for children in special circumstances and tier 1 mental health services were provided by PCTs (Fig. 4.2c). The targeted service most likely to be provided by other NHS trusts were services for children with a disability/special needs (30%) and safeguarding children services (25%).

Fig. 4.2c: Provision of targeted services by PCTs and other NHS provider trusts



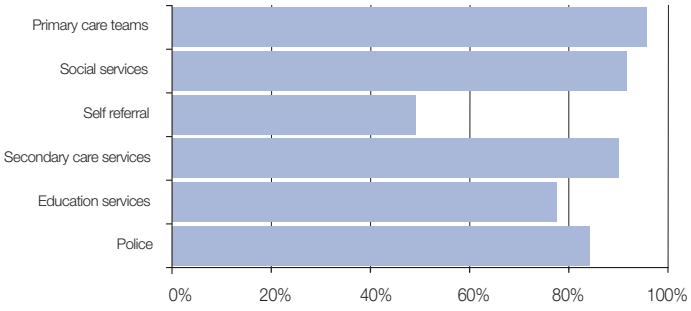
4.2.3 Age range

The age range of children and young people who could access targeted services ran from birth to the age of 25. However, the majority of services had an upper age limit of 18 to 19 years (Table 4.2a). The only services to extend beyond this were community paediatric services and services for children in special circumstances, some of which continued their support into young adulthood. At the lower age band, services varied as to whether they treated/supported babies or not. The two services clearly working with children in their first year were paediatric therapy and safeguarding services, the latter having an important role with families pre-birth. Tier 1 mental health services tended not to accept children under the age of 4.

Table 4.2a: Age range seen by targeted services

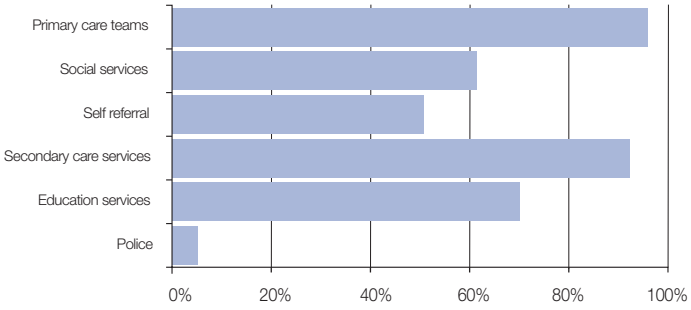
Service Type	Average lower age limit
Safeguarding children services	0
Mental health services outside specialist CAMHS	4
Other paediatric services managed in community	1
Paediatric therapy services	0
Services for children with a disability / special needs	1
Services for children in special circumstances	2
Total	**1**

Fig. 4.2d i: Source of referrals to safeguarding children services (N=280)



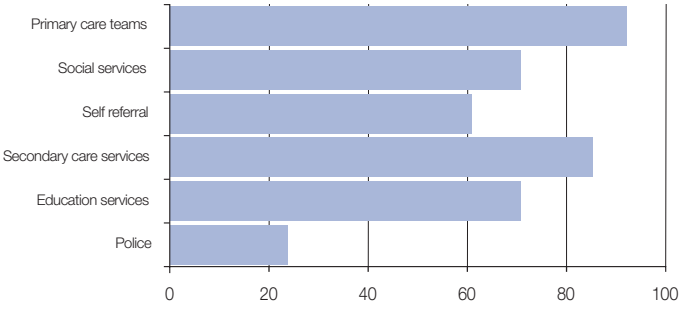
% of safeguarding children services indicating this referral source

Fig. 4.2d ii: Source of referrals to paediatric therapy services (N=423)



% of paediatric therapy services indicating this referral source

Fig. 4.2d iii: Sources of referrals to other paediatric services managed in the community (N=396)

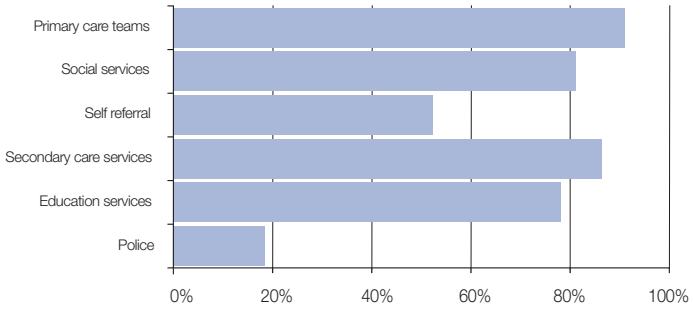


% of services for children with disabilities identifying this focus

4.2.4 Referral sources

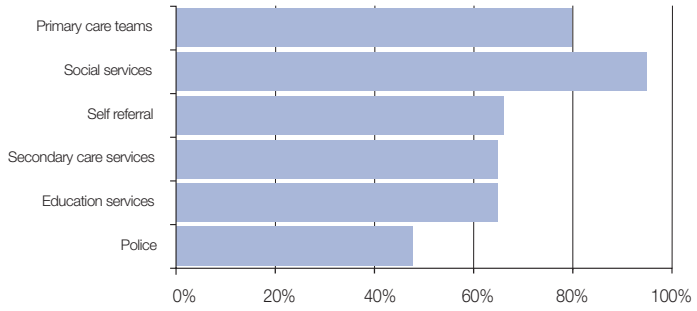
Targeted teams received their referrals from many agencies. Primary care was named as a referrals source by over 90% of targeted services (Figs. 4.2d i to vi). The only exceptions were services for children in special circumstances of which 79% of services cited this source (Fig. 4.2d v). Secondary care was a source of referrals for 80% of services overall, reflecting the referrals that are made between different specialties within children's services to meet the complex needs of many children using targeted services. 92% of paediatric therapy services, 90% of safeguarding children services and 86% of services for children in special circumstances named this source. Referrals from social services were recorded by 79% of targeted services. 94% of services for children in special circumstances and 92% of safeguarding children services recorded referrals from social services. Education was a referrer for 72% of services and the police for 38%. The police were the most significant referral source to safeguarding children services. Self referral was cited by 56% of targeted services and it was most likely to be identified by services for children in special circumstances (66%), community paediatric services (61%) and tier 1 mental health services (58%).

Fig. 4.2d iv: Source of referrals to services for children with a disability / special needs (N=343)



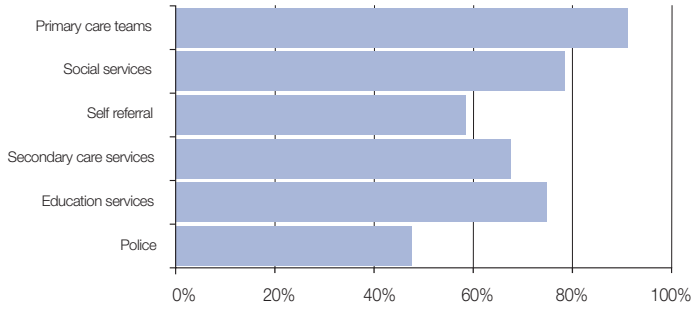
% of services for children with disabilities indicating this referral source

Fig. 4.2d v: Source of referrals to services for children in special circumstances (N=246)



% of services for children in special circumstances indicating this referral source

Fig. 4.2d vi: Source of referrals to mental health services outside specialist CAMHS (N=60)

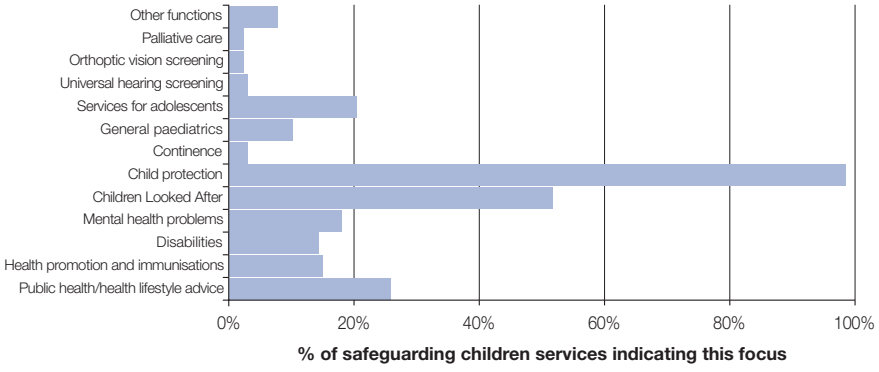


% of tier 1 CAMHS services indicating this referral source

4.2.5 Focus of work

As targeted teams are specialist services designed to meet a particular range of child health needs, the focus of each service type has been reported separately (Figs. 4.2e i-vi). However, it should be noted that the Mapping Helpdesk became aware that terms such as 'disability' were being interpreted differently between teams. Therefore the information is included here to illustrate general patterns rather than provide detailed analysis.

Fig. 4.2e i: Focus of work for safeguarding children services (N=280)



Some types of service were found to have a clear focus of work undertaken by the majority of services reporting, for example, as would be expected 100% of safeguarding children services reported child protection (Fig. 4.2e iii), but for other types of service, the focus reported varied around the country indicating the broad range of work undertaken (Figs. 4.2e i-vi).

Fig. 4.2e ii: Focus of work for paediatric therapy services (N=423)

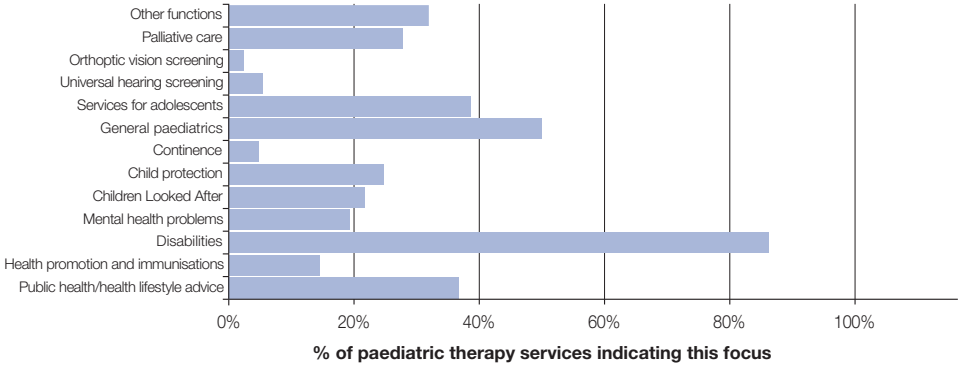


Fig. 4.2e iii: Focus of work for paediatric services managed in the community (N=396)

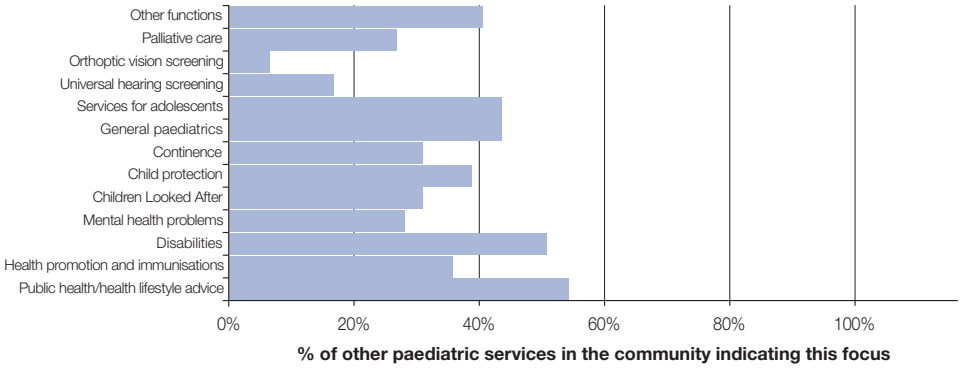


Fig. 4.2e iv: Focus of work for children with disabilities (N=343)

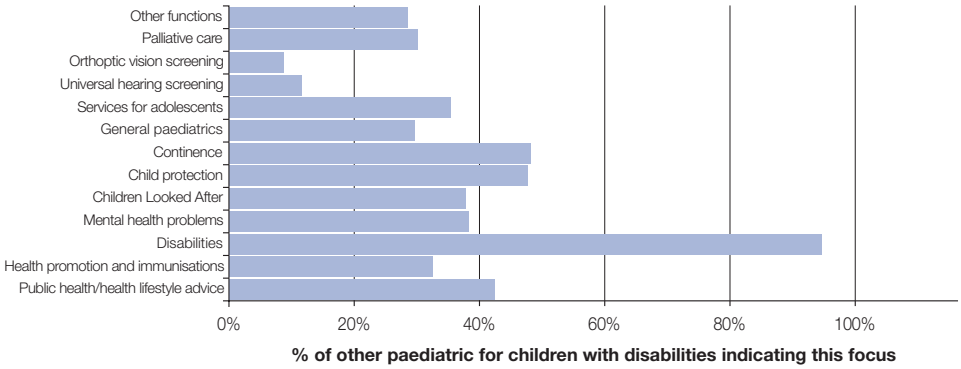


Fig. 4.2e v: Focus of work for services for children in special circumstances (N=246)

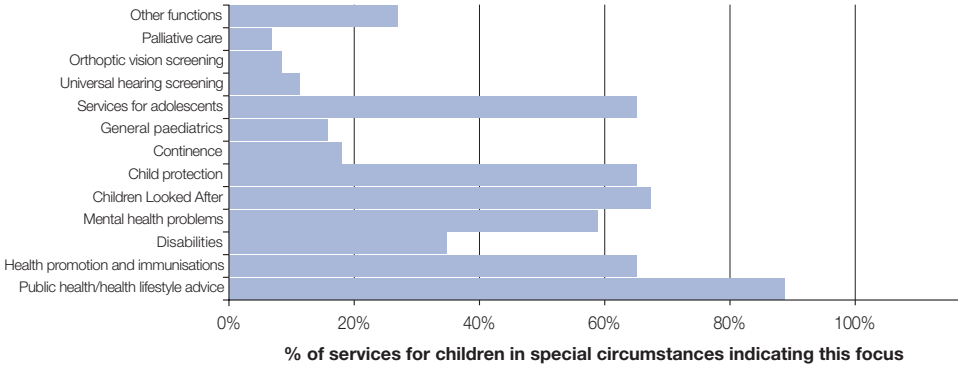
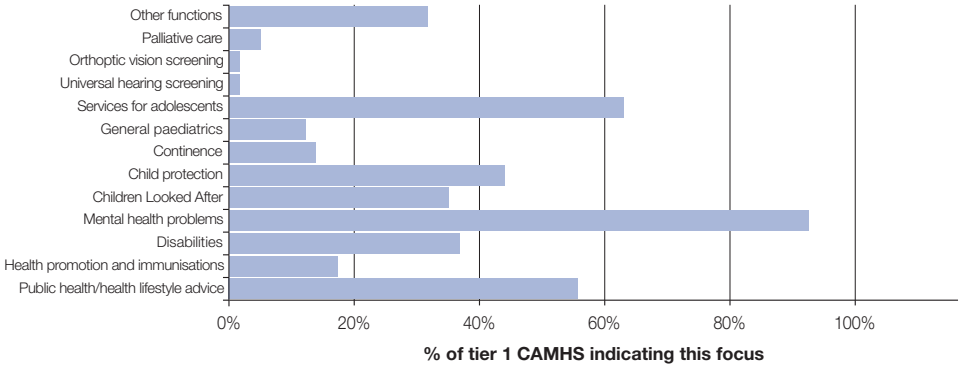


Fig. 4.2e vi: Focus of work for services for mental health services outside specialist CAMHS (N=60)

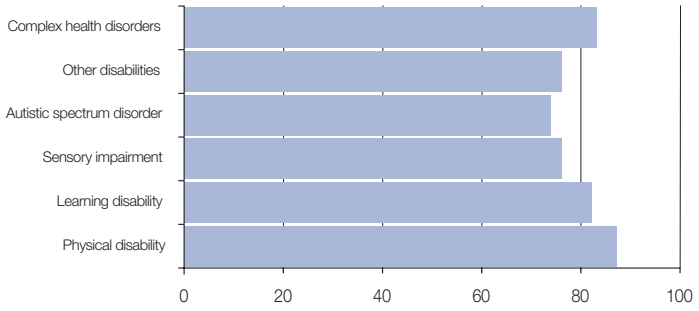


4.2.6 Disability

To further understand the range of work undertaken by services for children with disabilities and special needs, services were asked to indicate which types of disability they supported. 87% of services reported working with children with physical disability, 83% with children with complex needs and 82% with children with learning disabilities (Fig. 4.2f). Sensory impairment was a focus for 76% of services and 74% worked with children with autistic spectrum disorder. The overwhelming majority of services supported a range of disabilities but there were a few teams with a single focus such as autism, or physical disability.

It is recognised that provision of support for disabled children and young people cuts across service types within the mapping and so these services are explored in more detail in section 5.5.1.

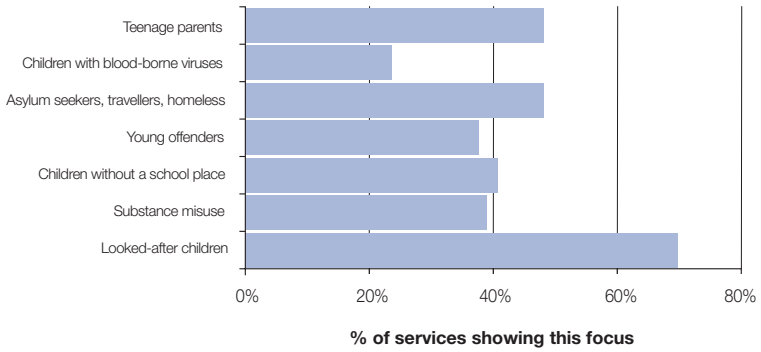
Fig. 4.2f: Services for children with disability - types of disability supported (N=343)



4.2.7 Children in special circumstances

To understand more fully who was being supported by services for children in special circumstances, they were asked to identify the broad groups of children and young people they provided for. Looked-after children were a focus for 70% of these services and teenage parents, asylum seekers and homeless children were a focus for 48% of services (Fig. 4.2g). Between 30% and 40% of services were supporting young offenders, substance misusers and children without school places. The wide variation of support needed by this range of young people helped to explain the very broad focus of work reported in Fig.4.2e v. However, there were also more narrowly focused teams within this service type. A total of 95 (39%) services had 'Looked-after children' in their name and clearly prioritise this work. Local intelligence suggests that general health needs for this group tend to be met by GPs and that targeted health provision often supports residential care provision and some specialist fostering situations.

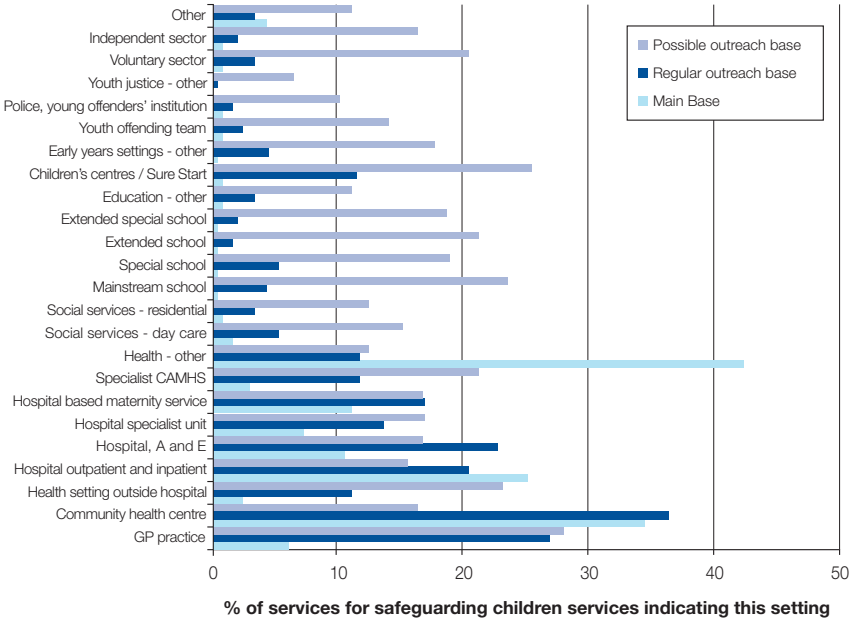
Fig. 4.2g: Target groups supported by services for children in special circumstances (N=246)



4.2.8 Work settings

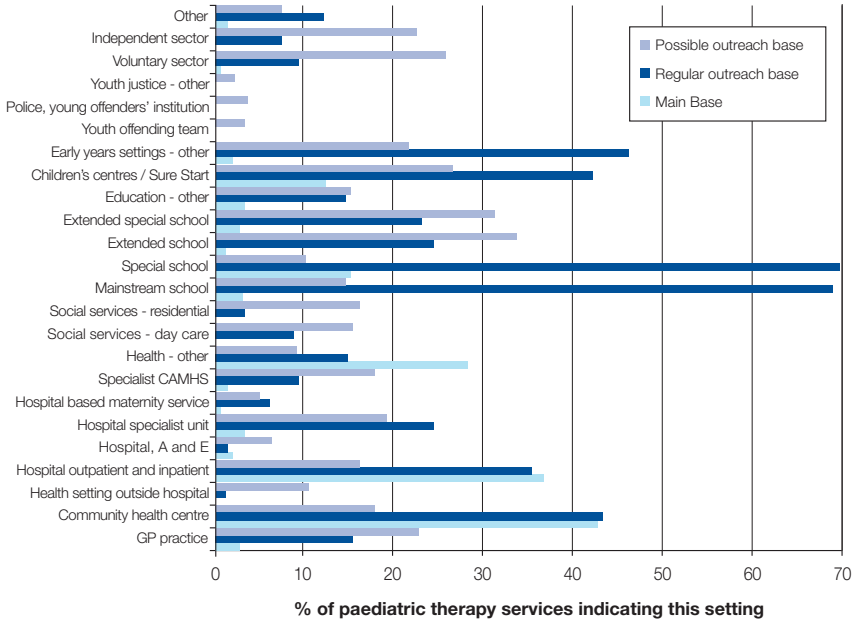
The majority of targeted services had their main base in community health settings but there was evidence of services extending into schools, children's centres, social care settings and the voluntary sector. Outreach work spanned a wide range of agency settings and there were indications of plans to further develop this trend. However particular characteristics were notable for each service type and these have been illustrated in Figs. 4.2h i to vi.

Fig. 4.2h i: Work settings for safeguarding children services (N=280)



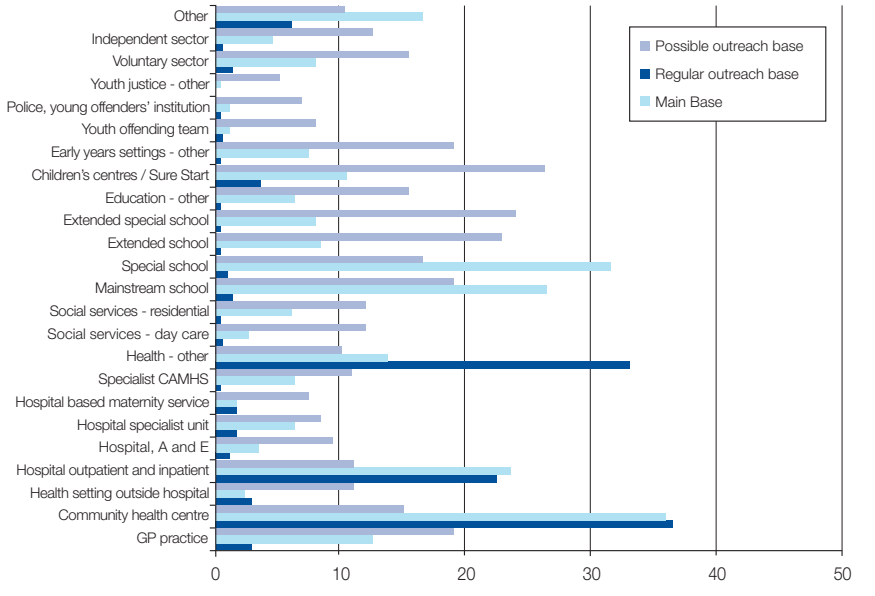
As this was health provision for safeguarding children, the services tended to be based in hospital and community health settings and outreach into these settings (Fig. 4.2h i). Outreach into schools and early years was undeveloped but identified as possible locations for outreach in the future along with settings in education, youth offending as well as the independent and voluntary sector.

Fig. 4.2h ii: Work settings for paediatric therapy services (N=423)



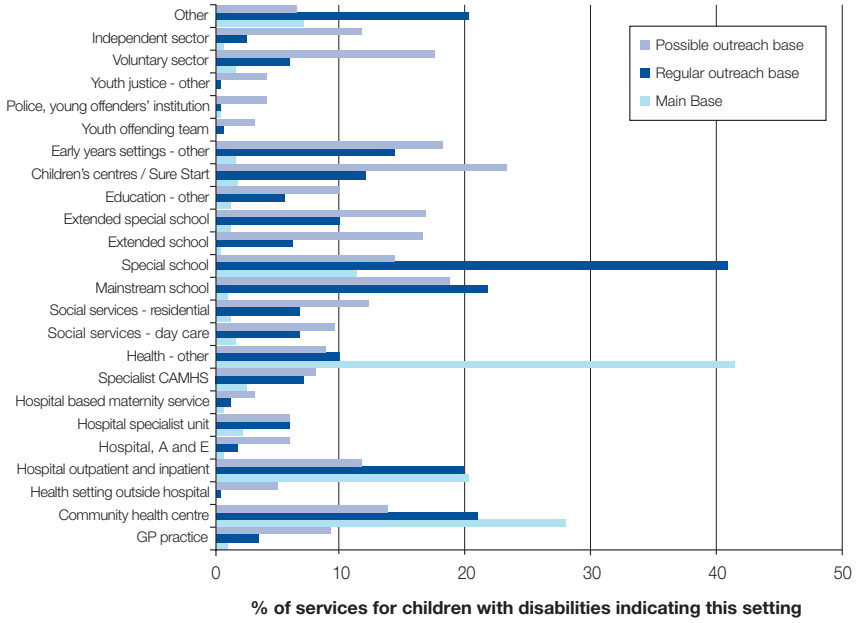
Paediatric therapy services tended to be based in a range of health settings but some had main bases in schools and early years provision. 70% of services currently outreach into mainstream and special schools and over 40% into early years services (Fig. 4.2h ii). Future outreach work could expand into extended schools, early years services and the voluntary and independent sectors.

Fig. 4.2h iii: Work settings for other community paediatric services (N=396)



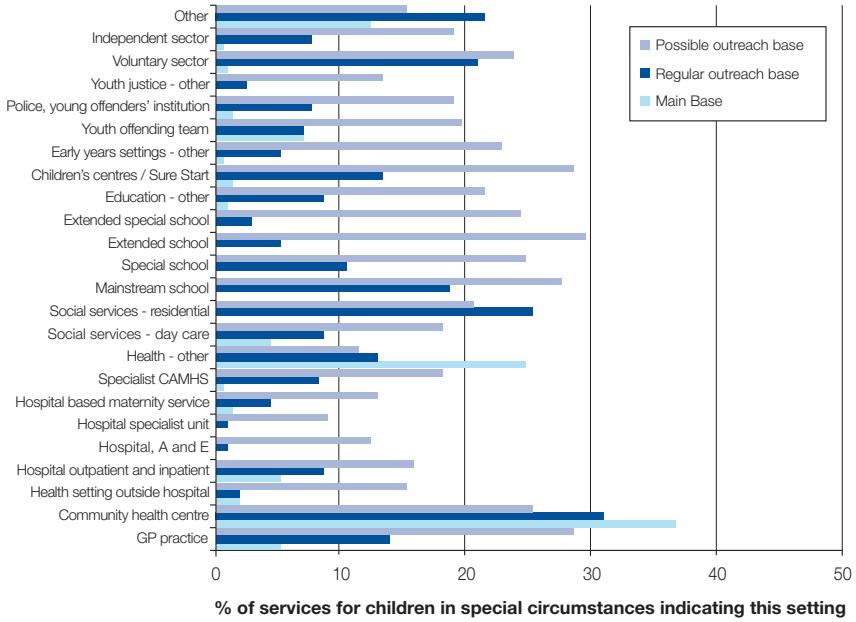
Other paediatric services managed in the community tended to be based in health settings in community health centres, hospitals or other health premises (Fig. 4.2h iii). A few services had developed a base in early years settings. Outreach was mainly to health and education, especially mainstream and special schools. Possible future work aims to extend outreach into extended schools and early years.

Fig. 4.2h iv: Work settings for services for children with disabilities and special needs (N=343)



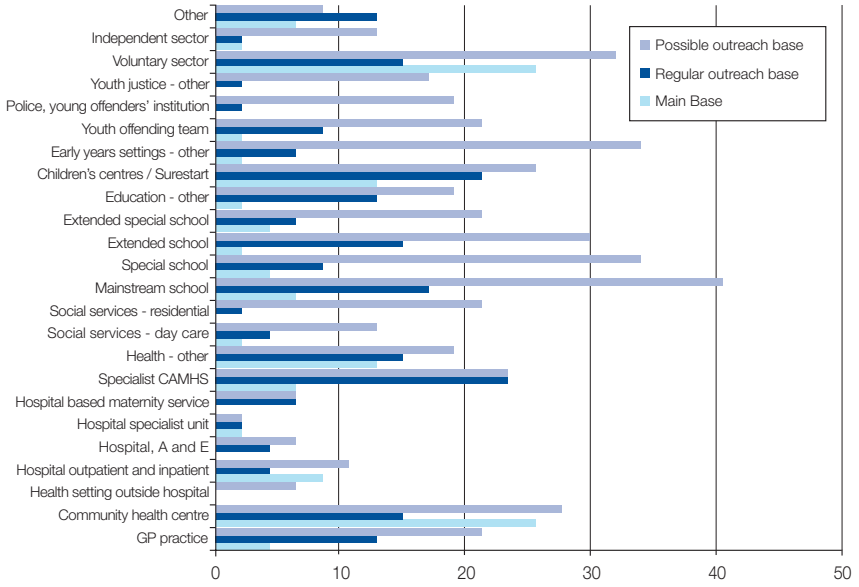
Some services working with children with disabilities were located in special schools but the majority were based in community health centres, hospitals or other health settings (Fig. 4.2h iv). Outreach tended to be into schools, particularly special schools and early years services. Planned outreach indicated increased use of health settings, schools (especially extended schools), early years, Children's Centres and the independent sector.

Fig. 4.2h v: Work settings for services for children in special circumstances (N=246)



Services for children in special circumstances were principally located in community health centres and other community health settings (Fig. 4.2h v). They outreached into social services residential and day care provision and undertook some work in schools, especially mainstream schools. Possible expansion of outreach into schools early years and youth justice was proposed as well as the development of links with the independent sector.

Fig. 4.2h vi: Work settings for mental health services outside specialist CAMHS (N=60)



Tier 1 mental health services had very scattered provision with 26% of services having a main base in the voluntary sector (Fig. 4.2h vi). Outreach was similarly varied in a range of schools and community health settings. 28% of services outreached into specialist CAMHS services. Possible future outreach indicated extension into schools, early years, youth offending and the voluntary sector.

4.2.9 Workforce

The workforce in post in targeted services was 14,594 WTE of which 39% were therapy staff, 21% nursing staff, 9% medical staff and 10% unqualified staff. There was also the support of 2,467 WTE administrators, 17% of the total workforce.

The deployment of different professional groups within services reflected the key functions recorded for the services. Hence, 88% of the paediatric therapy service workforce was therapists – the only other staff group of any size in these services were administrators (8%). Safeguarding children services were dominated by nurses (60% of the workforce) and doctors (13%) as these services provide the health input to interagency safeguarding provision. Non- professionally qualified staff were primarily located within disability/special needs teams.

Table 4.2b: Workforce in post in targeted services recorded in WTE

Service Type	Total staff	Medical staff	Nursing staff	Therapy staff	Scientific/technical staff	Midwifery staff	Non-qualified staff	Admin staff	Other staff
Safeguarding children services	1325	166	791	40	3	105	10	209	2
Paediatric therapy services	5581	41	158	4889	1	-	46	446	1
Other paediatric services managed in the community	3076	590	796	193	1	19	319	973	185
Services for children with a disability / special needs	3740	388	929	435	4	0	1018	683	282
Services for children in special circumstances	756	66	332	121	-	10	56	125	46
Mental health services outside specialist CAMHS	116	3	27	37	-	1	20	18	11
Total	**14594**	**1254**	**3032**	**5715**	**9**	**134**	**1469**	**2453**	**527**

Other community paediatric services also had a high proportion of doctors (19%) and nursing staff (26%). These services also had a large number of administrators (32%) but this was because the stand alone administrative teams who run the childhood immunisation and community health service programmes were often co-located with community paediatric services and there was nowhere more appropriate to locate them in the mapping.

Services for children with disabilities had input from a range of professionals – 10% medical staff, 24% nurses, 12% therapists and 26% non-qualified support staff. This contrasted with services for children in special circumstances which were resourced largely of nursing staff (44%) with 16% therapists and 9% medical staff.

A total of almost 7,000 WTE allied health professionals were employed in targeted services. 2,544 WTE (36%) were speech and language therapists, 1222 WTE (17%) were physiotherapists and 840 WTE (12%) were occupational therapists (Table 4.2c). Over 70% of the therapy workforce worked in paediatric therapy services.

Table 4.2c: WTE of allied health professionals employed in targeted services

Therapist	Safeguarding children services	Paediatric therapy services	Other paediatric services managed in the community	Services for children with a disability / special needs	Services for children in special circumstances	Mental health services outside specialist CAMHS	Total
Occupational therapists	6	640	13	96	1	3	840
Physiotherapists	8	881	9	84	-	-	1222
Speech and language therapists	1	2301	34	90	3	2	2544
Play therapists	3	5	8	22	0	2	355
Clinical psychologists	1	16	10	41	9	16	145
Audiologists	10	27	28	30	-	-	198
Podiatrists	-	118	14	0	-	-	134
Dieticians	2	101	14	5	0	0	235
Orthoptists	3	25	1	3	-	-	109
Orthotists	1	12	-	3	-	-	37
Art therapists	-	5	-	3	1	1	9
Drama therapists	-	2	1	0	1	0	4
Music therapists	-	6	0	3	-	-	11
Prosthetists	-	2	-	1	-	-	8
Child psychotherapists	-	1	1	2	2	4	20
Assistant occupational therapists	-	103	5	10	-	-	123
Assistant physiotherapists	4	229	2	20	-	-	273
Assistant speech & language therapists	1	348	14	6	100	-	479
Assistant psychologists	-	0	0	17	-	5	32
Other assistant therapists	-	65	40	99	5	4	217
Total	**40**	**4885**	**193**	**535**	**121**	**37**	**6997**

The vacancy rate carried by targeted services in 2006 was 9% overall. This rose to 17.8% for tier 1 mental health services and was lowest in safeguarding children services (6.8%) and services for children in special circumstances (6.3%) (Table 4.2d).

Table 4.2d: Vacancy rates in targeted services

Service Type	Total funded vacancies	Total establishment	Vacancy rate
Safeguarding children services	97	1423	6.8%
Paediatric therapy services	587	6168	9.5%
Other paediatric services managed in community	335	3411	9.8%
Services for children with a disability / special needs	356	4096	8.7%
Services for children in special circumstances	51	807	6.3%
Mental health services outside specialist CAMHS	25	142	17.8%
Total	**1452**	**16046**	**9%**

4.2.10 Observations from the field

This category of service generated the most queries during the mapping exercise because of the complexity of the services involved and their interrelated nature. The ambiguities of some of the service descriptions and definitions caused confusion for mappers and useful suggestions were made for improvement.

A key issue in the mapping of targeted services was the apportionment of staff time between services. As a result heavy reliance had to be made on estimating time spent in different roles, some of which were too intertwined to sensibly disentangle. Similarly, requests were made for the mapping to reflect integrated interagency working more successfully. Staff explained that they did not easily recognise the 6 service types used in the mapping although they were chosen to reflect standards of the NSF.

Mental health services were another area of difficulty and it is hoped that with the planned merger of CAMHS and child health mapping into a single exercise in autumn 2006, these issues will be addressed.

4.3 Hospital Services

Service definitions

Paediatric emergency services This service type includes a range of provisions whose primary function is the care of children presenting at accident and emergency departments. This may be a separate accident and emergency (A&E) facility for children with dedicated paediatric staff or an A&E department that has dedicated staff who treat children within a dedicated area of the general A&E unit.

General paediatrics This service type refers to all hospital-based activity, predominantly inpatient and outpatient work that deals with the health of the child.

Paediatric surgery This service type refers to those staff whose primary function is to undertake surgery on children when provided on child-specific operating lists. There may be a specific team dedicated to children's surgery or children's surgery may be undertaken by general surgeons on a sessional basis.

Paediatric intensive care units These are child specific intensive care units whose primary function is to provide level 2 care and above.

Specialist paediatric services This service type refers to services provided or overseen by a third tier consultant, possibly within a managed network spanning one or more strategic health authorities.

Neonatal intensive care units Neonatal Intensive Care Units (NICUs) offer level 3 care for babies who require considerable help with breathing as well as feeding and/or whose weight is low and who require intravenous fluids.

Note on staff resource:

The staff resource mapped for each service should capture:

- staff who work exclusively within the service being mapped
- part-time staff who may provide sessional input to another type of paediatric service
- the input of staff whose primary function may be within a different service type
- only the time spent working in the service being recorded should be included. For staff who work across two or more services, the time spent in each should be apportioned.

4.3.1 Introduction

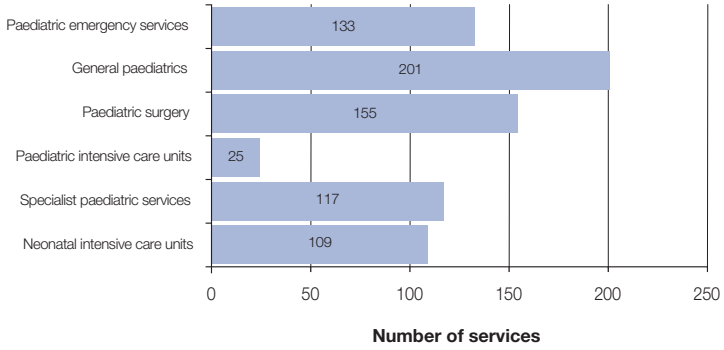
For the purpose of this exercise hospital services are services providing hospital based secondary care for children and young people and their families. These are services offered to a child or young person with specific needs, usually in response to a referral but also as an emergency when admitted through accident and emergency.

Information was collected on 6 service types which relate to standards 6 and 7 of the NSF. Standard 6 relates to children and young people who are ill and standard 7 covers children and young people in hospital. The service types included in the mapping were:

- Paediatric emergency services
- General paediatric services
- Paediatric surgery services
- Paediatric intensive care units (PICU)
- Specialised paediatric services
- Neonatal intensive care units (NICU).

This chapter provides broad information about the nature and extent of services across England. More specific issues relating to each service type is covered in chapter 5 which describes progress against key policy objectives.

Fig. 4.3a: Number of hospital services mapped (N=740)



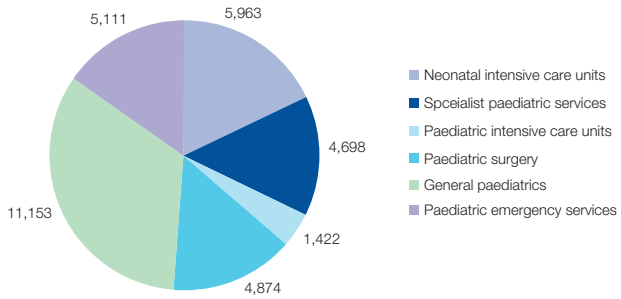
4.3.2 Service provision

There were a total of 740 hospital based services mapped. Of these, 201 services (27%) were general paediatric services and 155 (21%) were paediatric surgery (Fig. 4.3a). Together these two types of service accounted for 49% of the reported hospital service workforce. 11,153 WTE staff (34%) were employed in general paediatrics and 4,874 WTE (15%) in paediatric surgery (Fig. 4.3b).

The next largest group of services were paediatric emergency services which made up 18% (133 services) of the hospital based services reported and employed 15% of the hospital services staff resource (5,111 WTE). Specialist paediatric services made up 16% (117 services) of hospital based services, employing 14% of the hospital workforce (4,698 WTE) and 3% of hospital services were paediatric intensive care units (25 units). These employed 3% of the workforce (1,422 WTE).

Neonatal services accounted for 15% of hospital services mapped (109 in total) employing 18% of the hospital workforce (5,963 WTE).

Fig. 4.3b: Hospital services workforce by service type (Number of WTE staff)



4.3.3 Age range

Hospital based children's services usually worked with children and young people of all ages. The upper limit of services varied between 16 and 25 depending on the type of service delivered and on local transfer arrangements into adult services. Paediatric emergency services tended to provide for young adults and had an upper age limit averaging 24 years (Table 4.3a). These questions were irrelevant for neonatal services caring for newborn babies.

Table 4.3a: Average upper and lower age accepted by hospital services

Service Type	Average lower age limit	Average upper age limit
Paediatric emergency services	0	24
General paediatrics	0	17
Paediatric surgery	1	19
Paediatric intensive care units	0	16
Specialists paediatric services	0	18
Neonatal intensive care units	0	-
Total	**1**	**19**

4.3.4 Location of services

As with community-based services, hospital services were asked to indicate the location(s) of their main base and the settings in which they provided an outreach service. Figs. 4.3c i-vi report the findings. Paediatric emergency services were largely based in hospital A&E departments. 87% of services were located in A&E, 22% in hospitals (outpatient and inpatient units) and 4% in specialist hospital unit (Fig. 4.3c i). 11% of services also reported working in health settings outside the hospital but it was unclear what form this work took. Outreach was very limited and little expansion of this was planned.

Fig. 4.3c i: Work settings for emergency paediatric services (N=133)

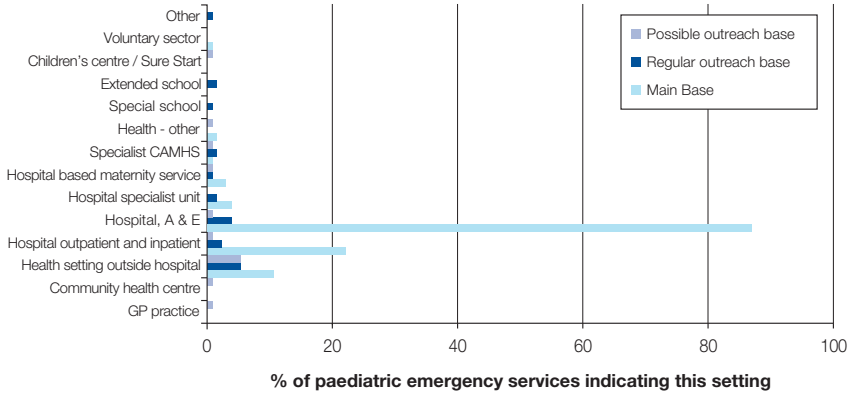
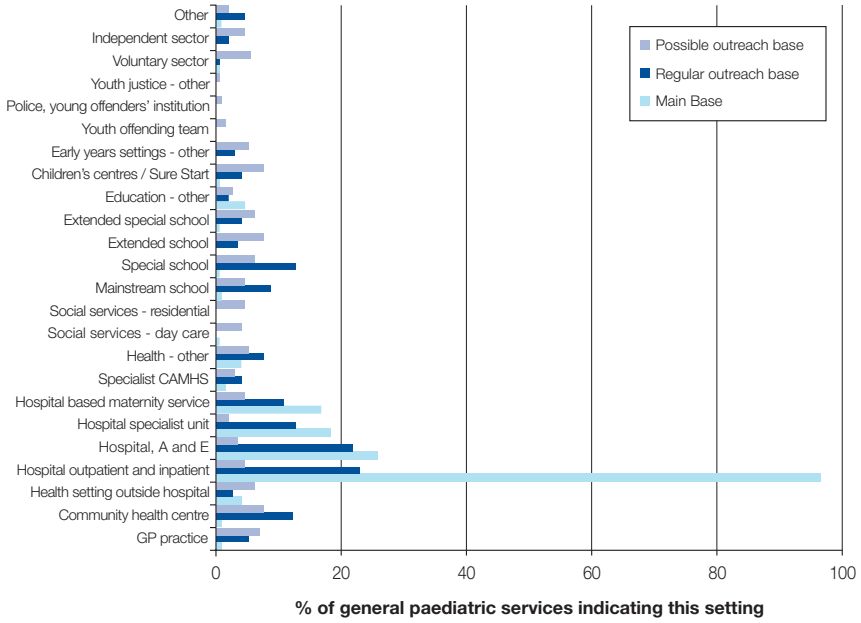
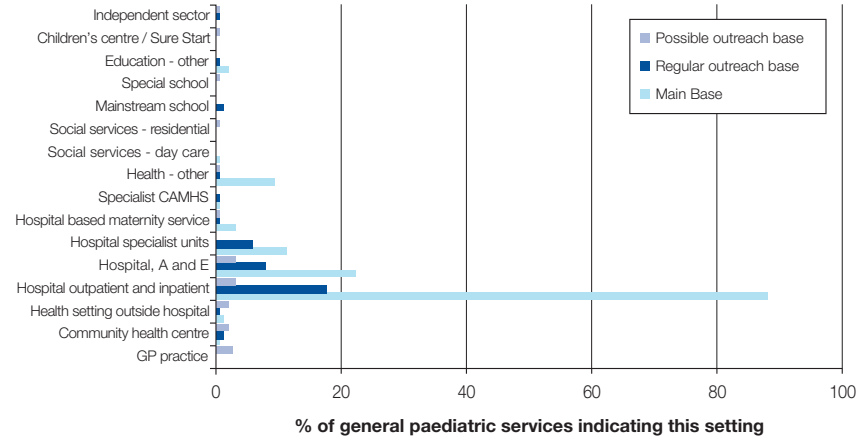


Fig. 4.3c ii: Work settings for general paediatric services (N=201)



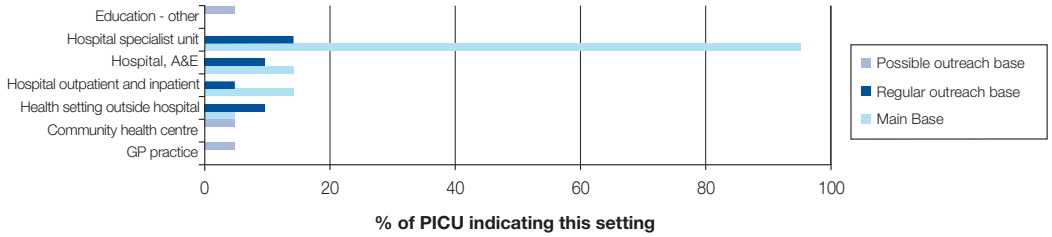
Of the general paediatric services, 96% had a hospital base, 26% reported a base in A&E, 18% in specialist units and 17% in maternity units (Fig. 4.3c ii). A few services had a community base - 4% had a base in an education setting. Outreach services were limited but 13% went into special schools and 5% into extended schools. There were indications that this outreach could be extended in the future to strengthen links with social services and early years services.

Fig. 4.3c iii: Work settings for general paediatric services (N=201)



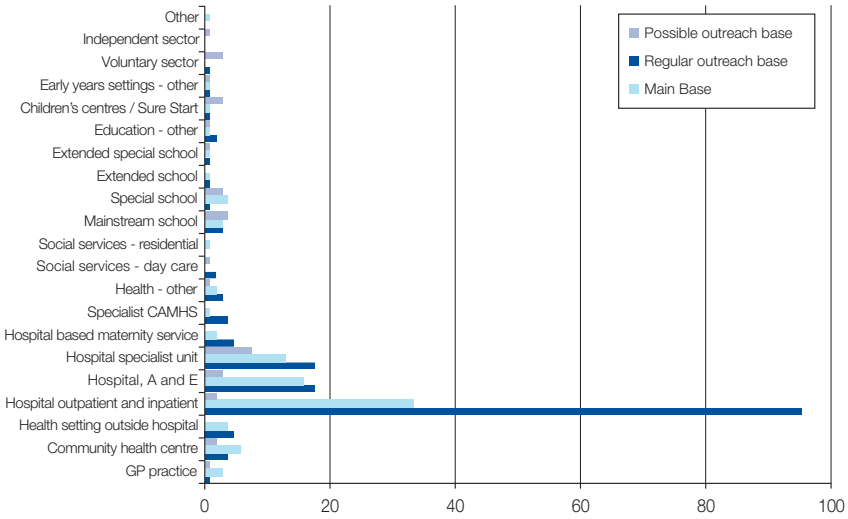
Of the paediatric surgery services, 88% had a main base located in hospital, 22% in A&E, 11% in specialist units and 9% in other health settings (Fig. 4.3c iii). One or two services reported a base in an education setting. Outreach was very limited.

Fig. 4.3c iv: Work settings for PICU (N= 25)



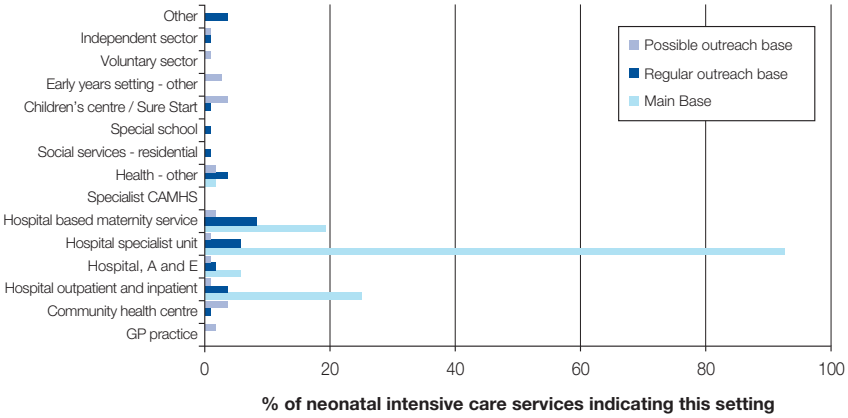
Almost all PICU had a main base in specialist hospital units (Fig. 4.3c iv). 14% of PICU had bases elsewhere in hospitals, 14% had bases in A&E and 5% had a base outside the hospital. Few PICU delivered outreach.

Fig. 4.3c v: Work settings for specialist paediatric services (N=117)



95% of specialist paediatric services were located in hospital with 18% having a base in specialist units and 18% in A&E (Fig. 4.3c v). A small number of services also had bases in community and education settings. Outreach was predominantly within hospital units.

Fig. 4.3c vi: Work settings for neonatal intensive care services (N=109)



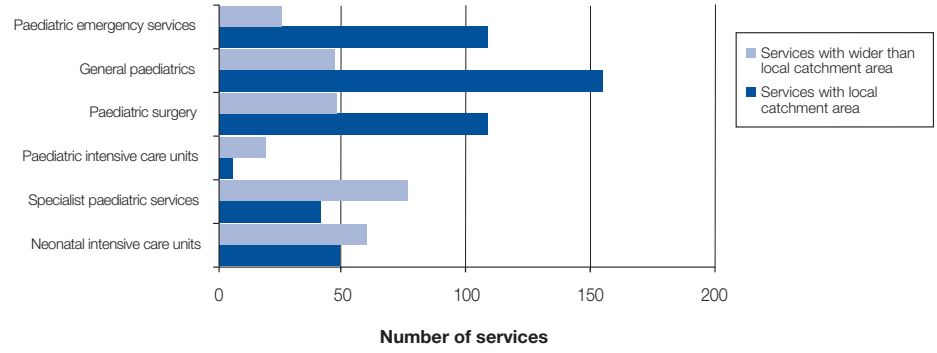
NICU tended to be based in specialist hospital units. 93% had bases in specialist units, 20% in maternity, 6% in A&E and 25% in other hospital settings (Fig 4.3c vi).

4.3.5 Hospital services catchment

Overall, 63% of hospital services mapped served a local catchment area only. This means that the services were commissioned to provide a service for a defined local population. In particular, emergency services, general paediatrics and paediatric surgery was provided in local services. 81% of emergency services, 77% of general paediatrics and 70% of surgery services served a local population (Fig. 4.3d).

Wider than local services served areas that included one or more SHA and the services could be regional or national. 76% of PICU had a wider than local catchment area, 65% of specialist paediatric services and 55% of NICU.

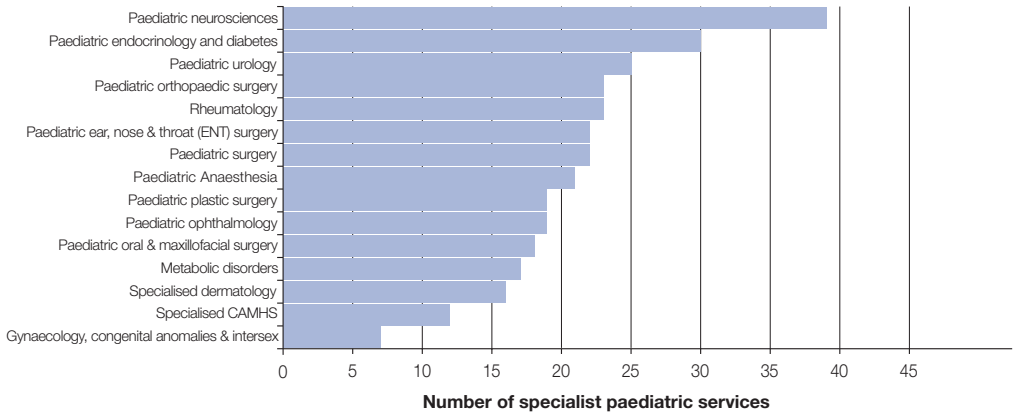
Fig. 4.3d: Catchment served by hospital services (N=740)



4.3.6 Specialist paediatric services

The range of work undertaken by specialist paediatric services is summarised in Fig. 4.3e. This shows the range of specialisms provided and the number of services available nationally.

Fig. 4.3e: Details of work undertaken by specialist paediatric services (N=117)



4.3.7 Workforce

The total hospital service workforce mapped was in excess of 33,221 WTE of which 16,700 WTE (50%) were nurses and 8,900 WTE (27%) were medical staff. Only a small number of other professional groups were employed, i.e. 3,000 WTE (9%) administrative staff, 2,500 WTE (8%) non-qualified staff and 1,000 WTE (3%) therapy staff (Table 4.3b). The latter two groups being predominantly employed in general paediatric services.

Table 4.3b: Workforce in post in hospital services recorded in WTE

Service Type	Total staff	Medical staff	Nursing staff	Therapy staff	Scientific/technical staff	Midwifery staff	Non-qualified staff 1	Admin staff	Other staff
Paediatric emergency services	5,111	1,303	2,901	21	4	-	433	432	18
General paediatrics	11,153	2,926	5,107	401	60	298	1,140	1,179	42
Paediatric surgery	4,874	2,085	1,676	237	24	-	316	478	59
Paediatric intensive care units	1,422	211	1,064	21	10	18	45	49	4
Specialist paediatric services	4,698	1,088	2,334	321	64	2	197	660	31
Neonatal intensive care units	5,963	1,248	3,638	32	16	314	429	255	30
Total	**33,221**	**8,861**	**16,719**	**1,033**	**179**	**631**	**2,560**	**3,052**	**185**

The balance of nursing and medical staff varied with the type of service. Paediatric surgery was dominated by medical staff. They made up 43% of the workforce and nursing staff 34%. In intensive care services high levels of nursing staff were recorded. They made up 75% of the staff of PICU and 61% of the staff of NICU.

Recorded vacancy rates in hospital services ranged from 3.35% in specialist paediatric services to 9.6% in PICU (Table 4.3c). These are generally lower than in universal and targeted services.

Table 4.3c: Vacancy rates in hospital services

Service Type	Total funded vacancies	Total establishment[1]	Vacancy rate[2]
Paediatric emergency services	337.9	5,449.2	6.2%
General paediatrics	679.9	11,832.7	5.7%
Paediatric surgery	497.6	5,371.8	9.3%
Paediatric intensive care units	151.7	1,573.9	9.6%
Specialist paediatric services	160.1	4,858.1	3.3%
Neonatal intensive care units	427.1	6,389.6	6.7%
Total	**2,254.2**	**35,475.3**	**6.4%**

1. Staff in post plus funded vacancies
2. Funded vacancies divided by establishment

4.3.8 Feedback from the field

Hospital services attracted a lot of queries to the Helpdesk during the mapping exercise because of a lack of clarity on what to record. Not only were there problems with staff working across the mapping service categories, but there were also difficulties in knowing what components of services to include where paediatric services were provided alongside adult services, such as, in surgery or A&E.

The distinction between paediatric surgery and paediatric specialist services was sometimes blurred as there was felt to be an inadequate explanation of what makes a specialist service specialist. In developing this service type it had been hoped that services would identify against the 'Gold Standard' of services for children laid down in the National Definition Set[6]. However, in actuality, very few services matched these criteria.
In paediatric emergency services, difficulties arose in mapping the provision of children's services within A&E departments. It was not possible to record the many innovative strategies in place to support children in A&E and the staff involved frequently worked with both children and adults.

Overall more detailed guidance is required on both service and staffing definitions.

4.4 Maternity Services

Definition

Antenatal care includes the full range of hospital and community based services providing pre birth care to all women in a variety of setting. Hospital based services are likely to include early pregnancy units that provide access to screening so that any concerns in the early stages of pregnancy can be quickly understood, antenatal wards for women with more serious problems who require inpatient care and outpatient clinics. Community based services are likely to include preconception services where women can seek specialist advice before becoming pregnant, access to a named midwife throughout pregnancy through a community midwifery service and community based antenatal clinics to ensure the early identification of issues.

Intrapartum care includes hospital and community based services for women in established labour. Hospital services include delivery suites and birthing pools. Community based services support women to give birth outside of the hospital environment, such as, community midwives who support home births.

Postnatal care includes hospital based care such as inpatient facilities and community based post natal care such as a community team which follows up mothers and babies after leaving hospital for up to 3 months dependent on need. Both types will have a multi disciplinary approach involving midwives, health visitors and maternity support workers working closely together to provide an integrated service.

Special Care Baby Unit (SCBU) is defined in the Department of Health (2003) Neonatal Intensive Care Review - Strategy for Improvement. SCBUs provide level 1 care for babies who are less than 1.75 kg but are fully breast or bottle fed.

4.4.1 Introduction

This section describes the findings from the maternity service data that was reported in the 2006 mapping exercise. Maternity services were included in the exercise because Standard 11 of the NSF sets out standards to ensure that women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies. In the original design of the mapping, it had been intended that a number of maternity services would be mapped to distinguish different functions such as antenatal care, postnatal care etc. However, during the piloting, it became clear that maternity service staff do not tend to work in this way. Usually they work flexibly across the service, contributing to two or more functional divisions within the service. As a result, maternity was consolidated into one service type with follow up questions about functions.

Despite facilitating the mapping of comprehensive maternity services in a single mapping record, it should be noted that this was not always felt to be the most appropriate way to record the configuration of local services. Therefore some teams with specific functions have been mapped separately, such as community midwifery teams or special care baby units. This does not mean that the team works in isolation from other parts of the local midwifery service. For example, because a SCBU has chosen to be recorded separately in the mapping exercise does not mean that it is divorced from the local intrapartum care team. This chapter reports what has been mapped. To obtain more detail on the full provision of maternity services the detailed mapping tables should be examined on the website.

This chapter provides broad information about the nature and extent of services across England. More specific issues relating to each service type is covered in chapter 5 which describes progress against key policy issues.

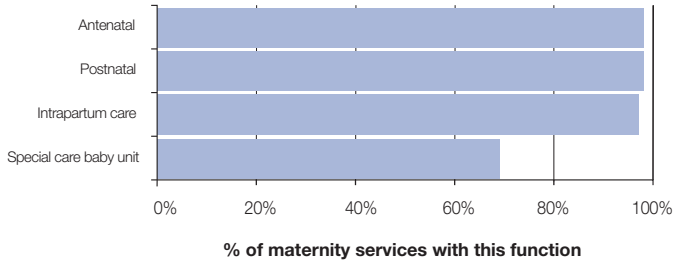
4.4.2 Services mapped

Altogether 160 maternity services were mapped, employing 25% of the child health and maternity service workforce (21,250 WTE). Of these, 97 (61%) services served a local catchment area only, while 63 (39%) services served a wider area that might be regional or sub-regional (Table 4.4a).

Table 4.4a: Catchment area of maternity services mapped

Services mapped	Services with local catchment area	Proportion of services with local catchment area	Services with wider than local catchment area	Proportion of services with wider than local catchment area
160	97	61%	63	39%

Fig. 4.4a: Function of maternity services (N= 160)



4.4.3 Service functions

Within the maternity services mapped, three services were dedicated SCBU. All the other services provided ante and postnatal care and all but one also provided intrapartum care (Fig. 4.4a). 69% of services reported provision of special care baby units but this does not mean that the remainder of services do not have access to special care for the babies who are born in their care – it may only indicate that the SCBU has been mapped separately or within another maternity service.

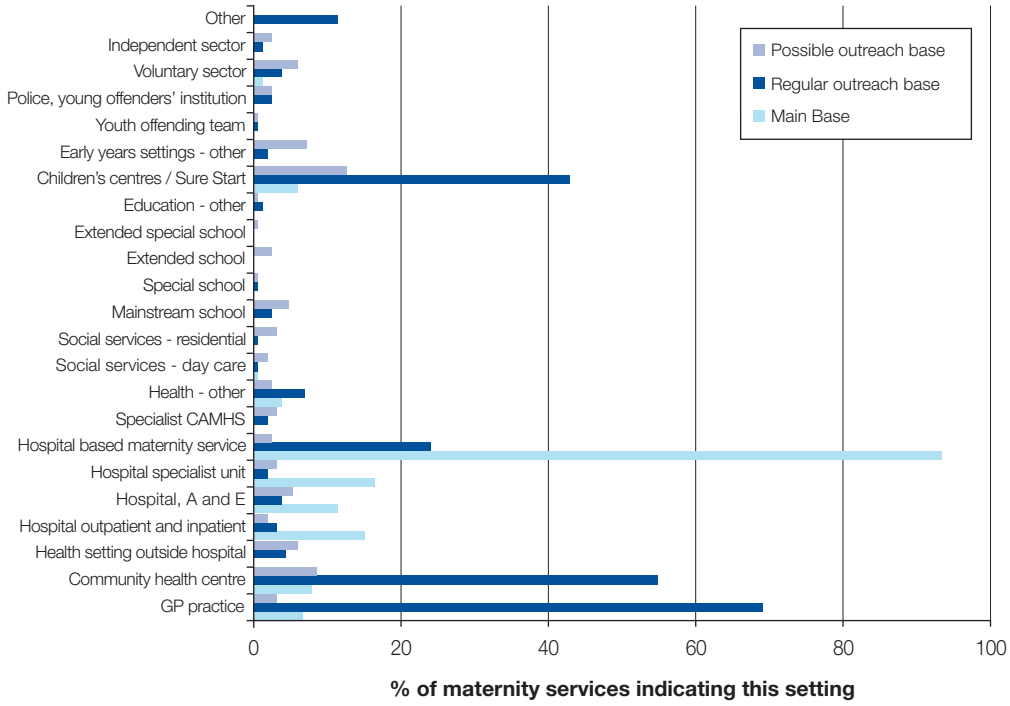
4.4.4 Service settings

Details of the settings from which maternity services operated were given for 149 (82%) services. Of these, all but 6 services (community midwife teams) were hospital based maternity services (Fig. 4.4b) but the majority of services worked from more than one main base. 24 services (17%) also worked in specialist hospital units and 17 services (11%) reported providing emergency maternity care in A&E departments. Only one service worked exclusively in a hospital specialist unit.

Twelve services using a community health centre base were reported and all but one community midwifery service worked additionally from GP practices or a hospital base. Thirteen services operated from non-health settings, 10 in early years/ children's centres, 2 from a voluntary agency and 1 from a social services day centre.

Outreach settings showed a reverse pattern with 83% of services outreaching into GP practices and 60% of services working into community health centres (Fig. 4.4b). Other health settings used were minor injuries clinics (5%), specialist CAMHS services (2%), A&E departments (4%) and specialist hospital units (2%). Importantly 43% of services were outreaching into early years centres and Sure Start, but there was little outreach into social services or education provision. Few services had plans to extend outreach.

Fig. 4.4b: Work setting for maternity services (N=149)

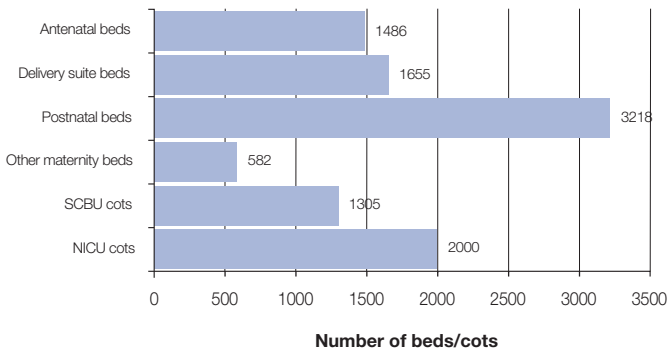


4.4.5 Maternity bed and cot provision

In total 6,941 maternity beds were mapped in 146 maternity services. Of these 46% were postnatal beds, 21% were antenatal beds and 24% were in delivery suites (Fig. 4.4c). In addition, 8% of beds (582) were described as 'other'.

As some NICU provide special care baby care in addition to intensive and high dependency care, the number of SCBU cots has been displayed alongside the capacity of NICU cots (Fig. 4.4c). Nationally, 1,305 cots were recorded in the SCBUs mapped and 2,000 cots in the NICU that were mapped. This is discussed further in section 5.4.8.

Fig. 4.4c: Number of maternity beds provided



4.4.6 Maternity beds and births

Taking the number of births recorded in the mapping, this maternity provision gives a national average of 59 births per maternity bed. The SHA average ranging from 40 to 81 (Table 4.4b and Map 4.4)

Map 4.4: Births per maternity service bed by SHA

CHM: Maternity Births per bed

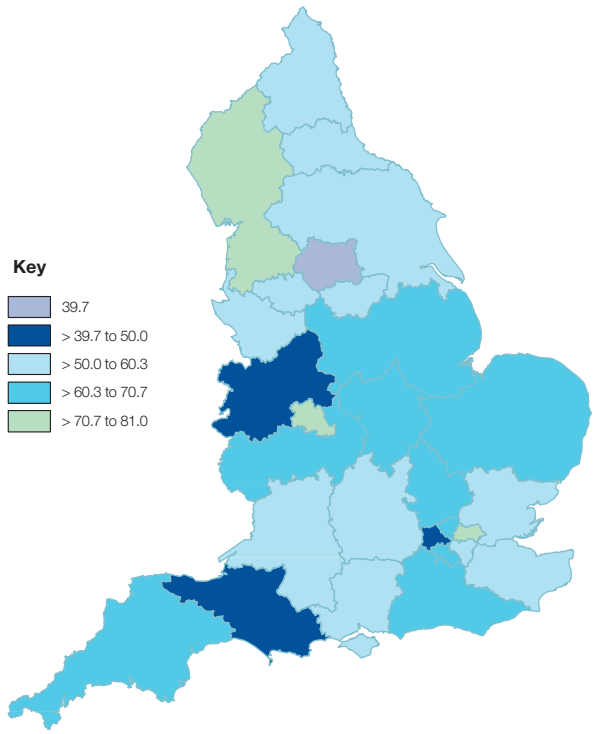


Table 4.4b: Maternity beds and births

Strategic Health Authority	Total maternity beds*	Antenatal beds*	Delivery suite beds**	Postnatal beds**	Other maternity beds**	SCBU cots***	Births[a]	Births per bed[aa]
Avon, Gloucestershire & Wiltshire	356	49	87	163	16	73	20906	59
Bedfordshire and Hertfordshire	267	40	53	106	20	47	18111	68
Birmingham & the Black Country	188	-	45	-	98	8	13609	72
Cheshire and Merseyside	332	98	70	168	8	48	18019	54
County Durham & Tees Valley	232	30	81	103	18	20	13894	60
Cumbria and Lancashire	246	22	58	161	7	48	19921	81
Dorset and Somerset	165	10	21	62	10	17	7543	46
Essex	236	51	47	122	16	24	13848	59
Greater Manchester	194	36	30	63	7	35	11364	59
Hampshire and Isle of Wight	222	39	41	43	49	21	11877	54
Kent and Medway	303	68	75	140	3	95	18153	60
Leicester, Northants & Rutland	217	-	18	124	-	-	13347	62
Norfolk, Suffolk & Cambridgeshire	284	57	75	133	19	55	18567	65
N & E Yorkshire & N Lincolnshire	139	22	26	54	-	26	7765	56
North Central London	234	64	47	105	17	59	15984	68
North East London	346	88	69	171	19	67	26295	76
North West London	266	75	56	122	13	51	11952	45
Northumberland, Tyne and Wear	206	19	61	143	11	46	10471	51
Shropshire and Staffordshire	212	57	41	97	17	-	10323	49
South East London	443	100	116	172	15	121	23949	54
South West London	160	39	36	77	6	28	11209	70
South West Peninsula	250	72	52	123	20	52	16117	64
South Yorkshire	287	131	58	111	11	47	16513	58
Surrey and Sussex	149	25	41	84	4	23	9867	66
Thames Valley	365	34	71	104	106	89	20883	57
Trent	243	29	65	62	59	44	15384	63
West Midlands South	329	104	75	181	1	63	19948	61
West Yorkshire	503	127	140	224	12	98	19975	40
Total	**7374**	**1486**	**1655**	**3218**	**582**	**1305**	**435794**	**59**

*Excluding SCBU
**Where these are separately identified[a] Births for the year April 2004 to March 31st 2005, regardless of setting
***Special Care Baby Unit cots outside NICU (neonatal intensive care)
[aa]Total births divided by total beds

Table 4.4c: Maternity service workforce by professional group

Maternity service workforce	WTE in post	% of maternity workforce
Medical staff	2,673	13%
Nursing staff	367	2%
Therapy staff	34	0.2%
Scientific/technical staff	13	0.1%
Midwifery staff	13,481	63%
Maternity support workers	2,174	10%
Non-qualified staff	1,105	5%
Admin staff	1,362	6%
Other staff	27	0.1%
Total	**21,236**	

4.4.7 Maternity services workforce

The total workforce mapped in maternity services was 21,236 WTE, made up of 13,481 WTE midwives (63% of the workforce) and 2,673 WTE medical staff (13% of workforce) (Table 4.4c). Nursing staff accounted for 367 WTE posts (2%). Non-qualified staff accounted for 1,105 WTE (5%) and there were 2,174 WTE maternity support workers (10% of the workforce).

An analysis of the distribution of midwives and maternity support workers in other child health services showed that 687 midwives and 105 maternity support workers were working in a range of services. The majority worked in neonatal intensive care units and general paediatric services but over 100 midwives were working in safeguarding services (Table 4.4d).

Table 4.4d: Midwives and maternity support workers employed in other child health services (non-maternity services)

Child health service	Midwives WTE	Maternity Support Workers WTE
Mental health services outside specialist CAMHS	0.7	-
Specialist paediatric services	1.5	-
Early years & health visiting services	7.1	20.0
Services for childen in special circumstances	9.7	-
Other paediatric services managed in the community	11.5	7.0
Paediatric intensive care units	18.0	-
Safeguarding children services	104.7	-
General paediatrics	260.2	37.5
Neonatal intensive care units	273.6	40.4
Total	**687.0**	**104.9**

An overall vacancy rate in maternity services of 8.9% was reported (Table 4.4e) and the overall vacancy rate for midwives irrespective of the type of service worked in was 9%.

Table 4.4e: Vacancy rates in maternity services

	Total maternity workforce
Total funded vacancies	2087
Total establishment	23324
Vacancy rate	8.9%

4.4.8 Observations from the field

It was noted by many mappers that this service type was easier to complete than others. However, it did attract feedback. This focused on the difficulty of fitting services on the ground into the restrictions of the mapping structure. For example:

- Difficulties were experienced in providing a breakdown of beds in some services as they tend to be multifunctional – used for labour/delivery/recovery/postnatal as demand requires
- Where a SCBU unit was situated within the neonatal intensive care service and not maternity services, it was unclear where to map the service
- Where maternity services covered obstetrics and gynaecology, boundaries were difficult to draw
- It was unclear where to include specialist midwifery services, such as, teenage pregnancy midwife, drug abuse midwife or diabetic midwife
- The role of consultant midwife was not included in the staff groups.

4.5 Use of IT in child health and maternity services

All services were asked to indicate whether they had access to and used IT facilities. Questions focused on 6 aspects of internet and intranet use including use of email, the web, NHS Net, computerised case notes, summarised clinical information such as Cochran reviews and local health activity statistics. Table 4.5 reports the percentage of services that both have access to and use this IT. Although over 80% of services use email and the web, the NHS intranet is only used by 64% of services and only 24% have access to computerised activity data. Use of computerised clinical notes is very low at 14% of services nationally.

The service type that stood out for being low users of IT was paediatric intensive care services with only 64% having access and use of email and the web. Changes in this data will be very interesting to track in the future.

Table 4.5: Access to and use of IT - % of services in each service type

	Access to and use email	Access toand use internet	Access to and use NHS Net	Access to and use computerised clinical notes	Access to and use summarised clinical information	Access to and use activity statistics
Universal services						
Early years/health visiting services	87%	84%	61%	17%		30%
School health services	87%	86%	60%	9%		28%
Targeted services						
Paediatric therapy services	92%	90%	66%	10%		20%
Services for children with disability / special needs	87%	86%	58%	10%		20%
Safeguarding children services	91%	91%	67%	11%		19%
Services for children in special circumstances	85%	83%	51%	13%	0.1%	18%
Mental health services outside specialist CAMHS	72%	72%	37%	13%	0.2%	15%
Other paediatric services managed in the community	85%	84%	62%	13%		18%
Hospital services						
Paediatric emergency services	90%	89%	74%	24%	0.2%	28%
General paediatrics	95%	94%	72%	10%	0.1%	29%
Paediatric surgery	93%	94%	73%	15%	0.2%	34%
Paediatric intensive care units	64%	64%	48%	4%	0.1%	32%
Specialist paediatric service	87%	88%	77%	12%	0.1%	37%
Neonatal intensive care units	92%	92%	73%	16%		18%
Maternity services						
Maternity Services	89%	89%	70%	37%		26%
Total	**88%**	**87%**	**64%**	**14%**		**24%**

Chapter 5:

Progress Against National Child and Maternity Health Policy

This chapter provides information on a number of policy issues for which data has been collected from child health and maternity services through the mapping exercise. For ease of reference, policy areas have been aligned to the standards of the NSF. The chapter is structured as follows:

Mapping findings are reported only at national and strategic health authority levels within this report. Detailed tables and the full version of the report can be downloaded from the Child Mapping website at:

www.childhealthmapping.org.uk

5.1 Introduction

This chapter provides information on a range of government standards and targets relating to child health and maternity services included in the mapping exercise. For ease of reference, the policy areas have been aligned as far as possible to the themes of the NSF. They have been referenced where appropriate to remind us of the ways in which the mapping exercise will track progress in policy implementation over the coming years. We hope that this will assist services and commissioners to understand their own position with regards to child health service provision and identify where action should be targeted.

The content of this chapter was built up during the development phase of the mapping project. Interviews were held with clinicians, managers and policy makers in order to establish an understanding of the key issues facing stakeholders that could be captured in a national mapping exercise. In addition, a review of policy was undertaken to identify issues, standards and targets that would be:

- measurable through this form of national data collection
- referenced in at least one national policy document
- of importance to the field.

Most issues covered in this report will be covered in future mapping exercises so that trends in findings can be tracked over time and progress in achieving targets monitored. However, it is also expected that the content will change and adapt in response to emerging child health and maternity policy imperatives.

As with all other sections of this report, it is important to stress that this was the first child health and maternity service mapping exercise and it was a learning experience for everyone involved. Data may not be complete and detailed results should be read with care. We advise commissioners and providers to use the issues raised as a tool to identify areas for follow up and further investigation.

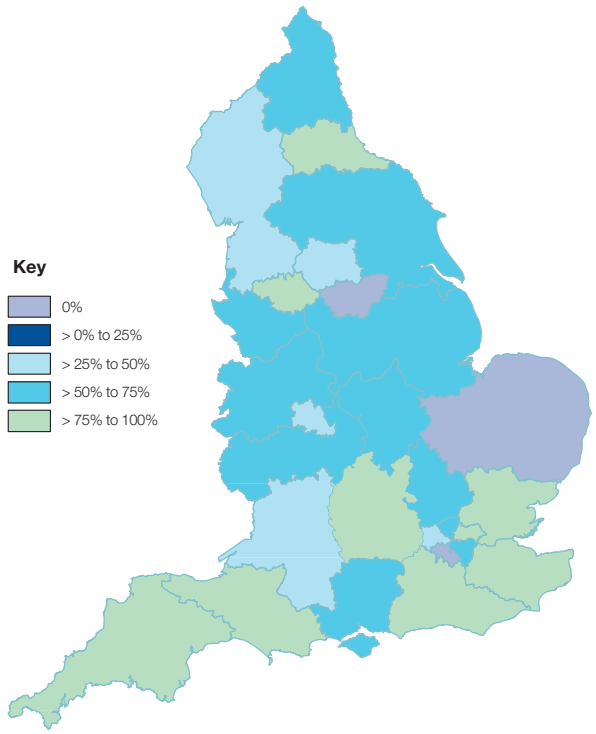
5.2 Standard 1 - Promoting Health and Well-being, Identify Needs and Early Intervention

The health and well-being of all children and young people is promoted and delivered through a co-ordinated programme of action, including prevention and early intervention wherever possible, to ensure long term gain, led by the NHS in partnership with local authorities.

National Service Framework for Children, Young People and Maternity Services

Service types aligned to this standard in the mapping exercise are the universal service types of early years, health visiting and school health services. Reference is also made to other service types and to requirements on PCTs to have strategies and arrangements in place. The emphasis in the NSF and other relevant policy, such as, the White Paper, Choosing Health[7] and the Chief Nursing Officer's Review[8], is on the development of broad based programmes of support to children and their families that will help address wider determinants of health and reduce health inequalities.

Map 5.2a: Percentage of PCTs reporting having a public health strategy (N=240)



5.2.1 PCT provision of public health strategy

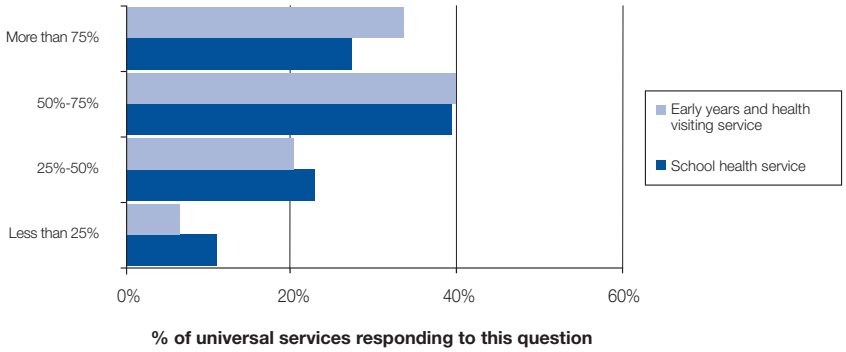
Since PCTs were given responsibility for public health in the NHS in 2003, they have played an important role in leading the development of local strategies and initiatives to improve the health and wellbeing of their communities. Given the importance of public health for children, young people and families, the mapping exercise included a question for PCT commissioners on whether they had an agreed public health strategy that clearly explains how the public health needs of children and young people will be met as set out in Choosing Health[9].

Of the 240 PCTs that completed the planning and service provision arrangements questionnaire, 154 (64%) had a public health strategy in place. The proportion of PCTs in SHAs reporting having a strategy ranged from 100% to none. (Map 5.2a). Unfortunately it is not possible to know if the 86 PCTs who did not answer this particular question, but did complete other sections of the questionnaire, left the question blank in error or because no strategy is in place.

5.2.2 Time spent on public health activities

Early years and health visiting and school health services play a key role in the delivery of health promotion programmes, lifestyle and public health advice and support to children and families[10]. In the mapping, these services were asked to identify the amount of time spent on activities linked to the public health agenda. The majority of early years and health visiting services (74%) reported that over 50% of their time was directed towards public health. 182 (40%) services estimated they spent between 50% and 75% of their time on public health, whilst 155 (34%) services spent over 75% on this work. In school health services 122 (39%) services spent from 50% to 75% of their time on this work and 85 (27%) services spent over 75% of their time on it (Fig. 5.2a).

Fig. 5.2a: Time spent on public health activities by universal services (N=768)



The emphasis of national policy on early years intervention and prevention services and the development of an enhanced public health role by community nurses means that we would expect these figures to show an increase over time.

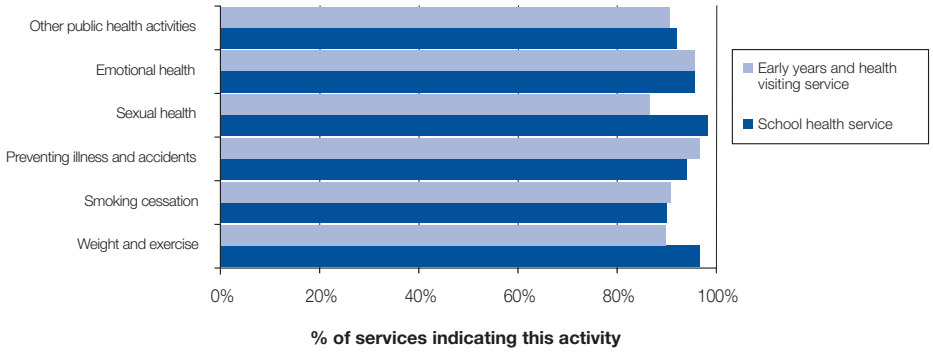
5.2.3 Public Health Advice

All PCT and LA have in place child and family health promotion programmes. As well as addressing individual needs, these include targeted programmes for vulnerable children and community based programmes addressing local and national public health priorities such as accident prevention, nutrition and physical activity.

National Service Framework for Children, Young People and Maternity Services[11]

Looking in more detail at the nature of the advice given by early years and health visiting and school health services, it was found that both service types covered similar areas of work (Fig. 5.2b). Over 85% of services reported providing all the types of advice listed but there were slight variations. School health services were more likely to be providing sexual health advice (98% of school health services as opposed to 87% of early years and health visiting services) and advice on weight and exercise (98% as opposed to 90%). Early years and health visiting services were more likely to be advising on illness and accident prevention (97% as opposed to 94%). 90-91% of all universal services advised on smoking cessation while 96% of all services provided advice on emotional health.

Fig. 5.2b: Public health advice provided by universal services (N=741)



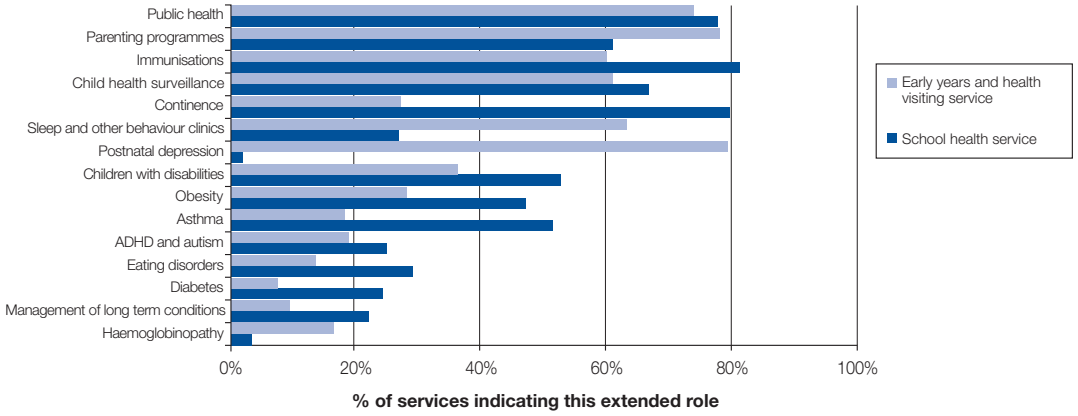
5.2.4 Extended nurse role

In 1992 the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) published 'The scope of professional practice'[12]. Broadly, it enabled nurses to move from a position of reliance on certification for tasks towards the development of professional autonomy. A review of the document in 1997 identified that the benefits of this approach for practitioners would include increasing job satisfaction and practice accountability. For patients and clients, benefits would be the promotion of seamless, high quality care and a reduction of anxiety, frustration or inconvenience[13]. Working in their extended roles, nurses have been encouraged to develop skills within particular specialisms, so increasing access to particular areas of specialist care.

Within the universal service type, services were asked to identify the range of extended roles developed by nurses in their staff team. The list was restricted to fifteen areas and overall, the most frequently cited special interest was in public health. 76% of services reported having nurses in an extended public health role. This was closely followed by nurses extending their role into the provision of parenting programmes (71%) and immunisation (69%).

Differences were apparent between early years and health visiting and school health services (Fig. 5.2c). Nurses in early years and health visiting services were more likely to become specialists in sleep and other behavioural needs (63%) and post-natal depression (80%). School nurses had a greater role in the provision of continence services (80%) and supporting children with particular conditions such as asthma (51%), ADHD and autism (25%), eating disorders (29%), diabetes (24%) and in the management of long-term conditions (22%).

Fig. 5.2c: Extended nurse role in universal services (N=656)



5.2.5 Nurse prescribing

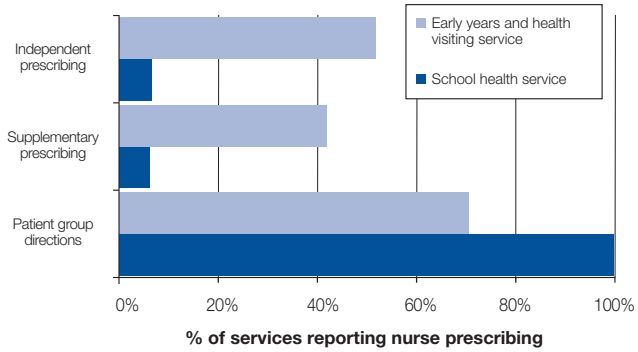
Definitions

Independent prescribing: Prescribing by a practitioner (e.g. doctor, dentist, nurse and pharmacist) responsible and accountable for the assessment of patients with undiagnosed conditions and for decisions about the clinical management required, including prescribing. Within medicines legislation the term used is 'appropriate practitioner'[14].

Supplementary prescribing: Prescribing in partnership with a doctor or dentist (the independent prescriber) to implement an agreed patient-specific Clinical Management Plan with the patient's agreement. Nurse and pharmacist supplementary prescribers are able to prescribe any medicine, including controlled drugs and unlicensed medicines, for the full range of medical conditions provided that are listed in an agreed Clinical Management Plan.

Patient group directions: are written instructions for the supply and/or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. Use of this should be reserved for those situations where this offers an advantage for patient care without compromising patient safety and where it is consistent with appropriate professional relationships and accountability[15].

Fig. 5.2d: Nurse prescribing (N=667)



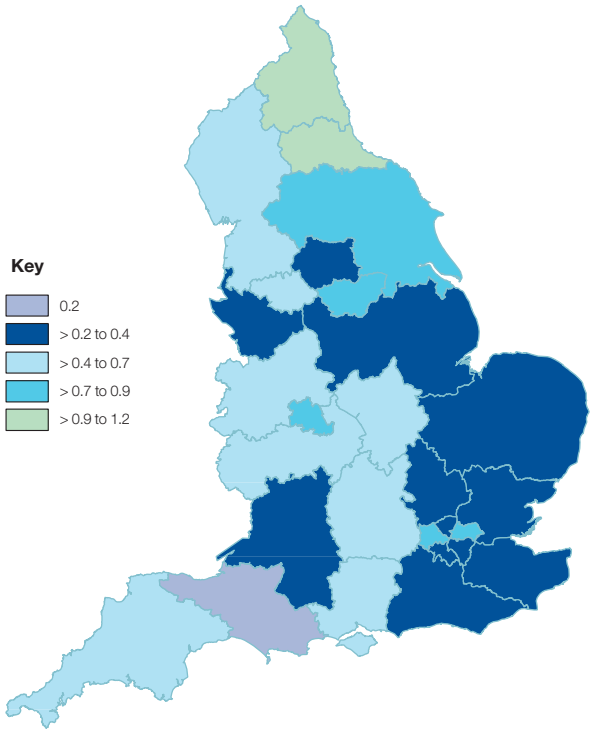
Within universal services, nurse prescribing was well developed and a range of nurse prescribing approaches were reported. For example, in early years and health visiting 71% of services reported prescribing under patient group directions, 52% independent prescribing and 42% practiced supplementary prescribing. In school health services, patient group directions were the most commonly used form of nurse prescribing, reported in 100% of services (Fig. 5.2d).

5.2.6 School clusters and health services in special schools

To address the shortfall in nursing provision for the school aged child, PCTs, children's trusts and local authorities are encouraged to work towards having at a minimum, one full-time, all year round, qualified school nurse for each school cluster or group of primary schools and its secondary school taking account of health needs and school population.

Chief Nursing Officer's review of the nursing, midwifery and health visiting contribution to vulnerable children and young people

Map 5.2b: School nurses per school cluster (N=285 services)



To estimate how well school health services were achieving the target of 1 WTE school nurse per school cluster, services were asked to identify how many school clusters they covered. This question was answered by 252 (73%) of the school health services mapped. Of the services responding, 9 (4%) services reported over 2 WTE school nurses per cluster, 55 (22%) reported between 1 and 2 WTE per school cluster and 187 (74%) services provided less than 1 WTE school nurse per cluster. Only one SHA area achieved the national target (Map 5.2b).

Altogether, 252 school health services employed 1,569 WTE school nurses and worked in 3,340 school clusters. This gave a national average of 0.5 nurses per cluster. There was some evidence of double counting of schools, but making allowances for this it was clear that national school nurse provision fell short of target in 2005.

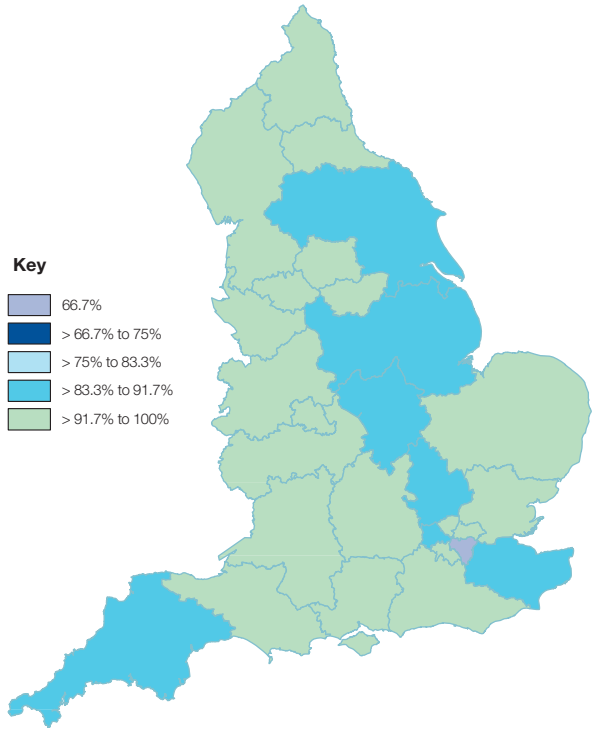
5.2.7 Hearing screening

The earlier a child's hearing impairment is identified and an appropriate intervention programme introduced, the greater the chances the children will develop better language skills, and enjoy benefits in speech, social and emotional development. (www.nhsp.info/faq.php)

The NHS Newborn Hearing Screening Programme (NHSP) was launched in 2001 to reduce the risk of babies and children experiencing undiagnosed hearing loss. Their work was reinforced in 2004 by the NSF which required PCTs to ensure that screening programmes were commissioned to meet national standards[16].

With this policy framework in mind, PCTs were asked if they commissioned an appropriate screening programme. Of the 238 PCTs that responded to the question, 232 (97%) PCTs had arrangements for neonatal hearing screening in place. 100% coverage was reported in 20 SHAs (Map 5.2c). This provides alternative findings to that reported in official guidance which states the NHSP is now fully implemented in every area of England although this anomaly could be explained by the variable completion rate in the mapping exercise.

Map 5.2c: Percentage of PCTs providing neonatal hearing screening



5.3 Standard 5 – Safeguarding and Promoting the Welfare of Children and Young People

All agencies work to prevent children suffering harm and to promote their welfare, provide them with the services they require to address their identified needs and safeguard children who are being or who are likely to be harmed.

National Service Framework for Children, Young People and Maternity Services

All policy emphasises the critical importance of high priority being given to the resources and processes established to deliver NHS responsibilities in relation to child protection and the safeguarding of children. The mapping exercise set out to collect information on three aspects of this: the availability of designated and named doctors and nurses; the level of access to a range of services 24 hours a day 7 days a week; and the focus given to safeguarding work by other child health services. The mapping exercise did not deal with other broader processes/system issues concerning child protection as these are audited through other means.

5.3.1 Safeguarding children staff

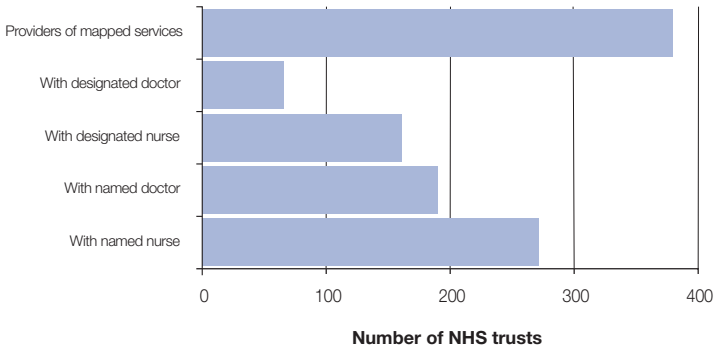
Every health authority is required to appoint a designated doctor and nurse to lead on all aspects of the health services contribution to safeguarding children[17]. Designated professionals work across trust boundaries providing a source of specialist advice, promoting and influencing relevant training and representing the health service on child protection committees. They also have responsibility for coordinating the activities of named professionals.

Every NHS trust that provides child health or obstetric service is required to appoint a named nurse or midwife and named doctor to take a professional lead on safeguarding children issues. Working in partnership with other professionals, named doctors and nurses have particular responsibility for:

- Clinical supervision of staff in child protection
- Planning and delivering training
- Quality audit and monitoring
- Promoting practice development
- Ensuring staff have access to appropriate legal advice/assistance[18].

In the 2005/6 mapping exercise, information about designated and named doctors and nurses was collected through individual services. When indicating their staff in post, services were asked to indicate time spent in these key safeguarding roles. In retrospect this was a very piecemeal way of collecting information about roles which operate across the whole trust area and, in the case of designated professionals, between trusts. The findings suggest many relevant staff were missed in the data collection. Therefore these findings should be treated as indicative figures only requiring further investigation.

Fig. 5.3a: Number of child health service NHS provider trusts with named and designated safeguarding children professionals



In the mapping exercise, 251 PCTs and 128 other NHS provider trusts recorded child health and maternity service provision – 379 NHS trusts in total. Overall, 66 (17%) PCTs and other NHS provider trusts reported

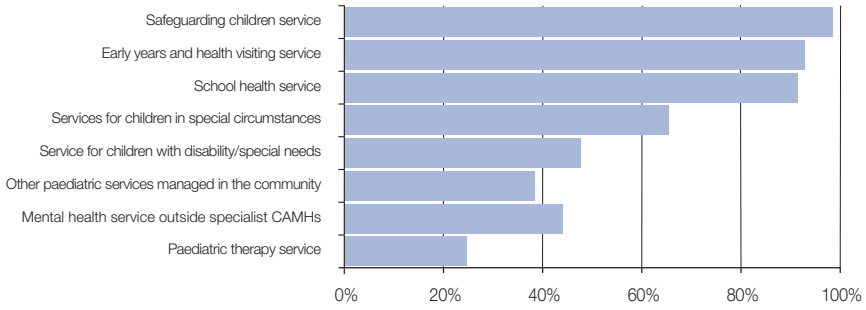
having a designated doctor working for a total of 112 WTE. Designated nurses were identified in 160 (42%) trusts providing a total of 176 WTE (Fig. 5.3a)

Named doctors were found in 190 (50%) trusts giving a total of 155 WTE to the role. Altogether there were named nurses in 271 (72%) trusts providing a total of 526 WTE.

5.3.2 Focus of work on safeguarding children

Safeguarding children was reported as a focus of work in all universal and targeted service types to a lesser or greater extent. As would be expected, all safeguarding children's services identified this focus. Over 90% of early years and health visiting and school health services also saw this work as a core function (Fig. 5.3b). Almost two-thirds (65%) of services for children in special circumstances reported this work, linked strongly to their responsibilities for looked-after children.

Fig. 5.3b: Focus of universal and targeted services on safeguarding children



5.3.3 Features of safeguarding children's services

Safeguarding services were asked about the range of services that were available on a 24 hour, 7-day a week basis. Most commonly available was the provision of information and advice (65% of services) and access to clinical advice (61% of services) (Fig. 5.3c). A telephone answering service was available in 58% of services. 47% of services offered 24/7 child protection medical examinations, whilst 45% of services offered a next day response. Ideally, services would offer all five features but Table 5.3b shows a wide variation in services across SHAs.

Fig. 5.3c: Provision of 24/7 response in safeguarding children services

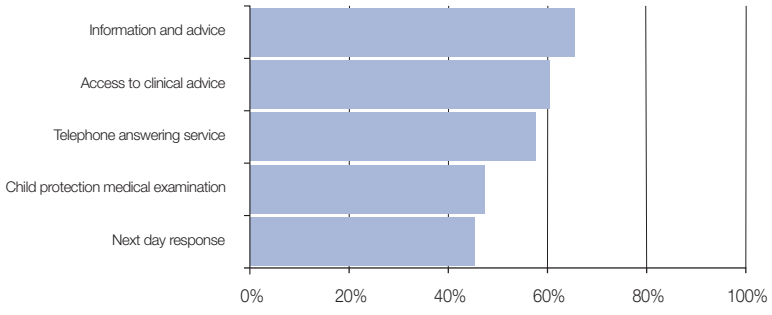


Table 5.3b: Provision of 24/7 features in safeguarding children services by SHA

Strategic Health Authority	Telephone answering service	Next day response	Access to clinical advice	Child protection medical examination	Information and advice
Avon, Gloucestershire & Wiltshire	91%	46%	55%	64%	64%
Bedfordshire and Hertfordshire	40%	60%	60%	30%	60%
Birmingham & the Black Country	70%	30%	40%	50%	70%
Cheshire and Merseyside	39%	31%	46%	54%	46%
County Durham & Tees Valley	57%	57%	71%	71%	86%
Cumbria and Lancashire	44%	31%	63%	31%	69%
Dorset and Somerset	39%	62%	23%	15%	23%
Essex	65%	29%	41%	53%	71%
Greater Manchester	67%	67%	100%	67%	100%
Hampshire and Isle of Wight	100%	88%	113%	63%	100%
Kent and Medway	100%	67%	78%	67%	67%
Leicester, Northants & Rutland	20%	10%	30%	10%	20%
Norfolk, Suffolk & Cambridgeshire	56%	33%	67%	56%	89%
N & E Yorkshire & N Lincolnshire	60%	40%	80%	60%	80%
North Central London	29%	29%	71%	57%	71%
North East London	40%	20%	80%	40%	80%
North West London	78%	44%	56%	33%	89%
Northumberland, Tyne and Wear	67%	83%	67%	50%	67%
Shropshire and Staffordshire	33%	33%	50%	33%	50%
South East London	29%	57%	43%	43%	43%
South West London	50%	50%	75%	50%	100%
South West Peninsula	67%	33%	67%	33%	50%
South Yorkshire	100%	100%	100%	100%	80%
Surrey and Sussex	29%	29%	43%	43%	43%
Thames Valley	30%	30%	60%	20%	60%
Trent	88%	88%	100%	100%	113%
West Midlands South	60%	40%	80%	60%	80%
West Yorkshire	100%	67%	50%	50%	50%
Total	**58%**	**45%**	**61%**	**47%**	**65%**

5.4 Standard 6 - Children and Young People who are ill and Standard 7 - Children and Young People in Hospital

Standard 6 – Children and Young People who are ill

All children and young people who are ill, or thought to be ill, or injured will have timely access to appropriate advice and to effective services which address their health, social, educational and emotional needs throughout the period of their illness.

Standard 7 – Children and Young People in Hospital

Children and young people receive high quality, evidence-based hospital care, developed through clinical governance and delivered in appropriate settings.

National Service Framework for Children, Young People and Maternity Services

The service types aligned to this standard are hospital services, paediatric emergency services, general paediatrics, paediatric surgery, paediatric intensive care units, specialist paediatric services and neonatal intensive care. In addition to the NSF, other policy that has influenced hospital care has been the Kennedy Report[19], the NSF for Long Term Conditions[20], the Children Act (1989 and 2004), Paediatric and Congenital Cardiac Services Review[21] and Neonatal Intensive Care Review - Strategy for Improvement[22].

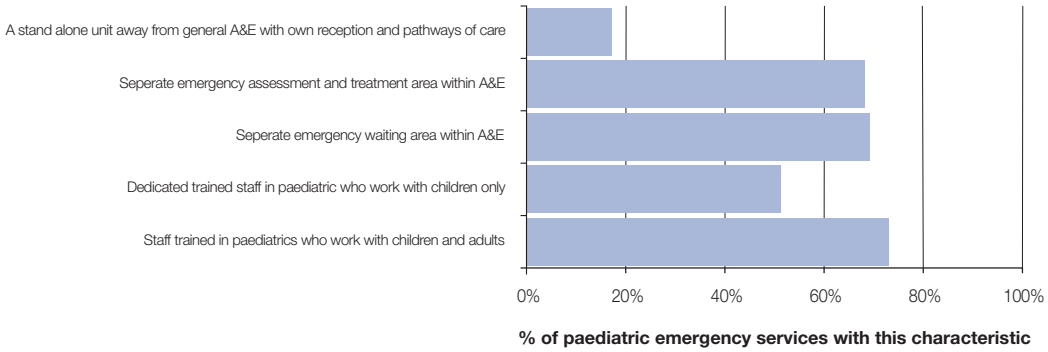
Policy stresses the importance of child friendly hospital care that provides appropriately for all levels of need whether it is around seeking help in emergencies, the provision of on-going support for complex conditions, surgery, acute illness or intensive care. The Kennedy Report has been very influential in pointing out the inappropriateness of much hospital care for children and the need to refocus on the child's needs. This has had an impact on every aspect of hospital care, including, the environment within hospitals, the information given to children, the treatment they receive, the arrangements for their care, the training of the workforce and quality standards. A child friendly hospital treats children and young people appropriately for their age, remembers the whole family and ensures easy transitions on admissions and on discharge back home[23].

5.4.1 Characteristics of paediatric emergency services

In a drive to improve hospital services for children and young people, dedicated pathways of care are being developed within hospital services[24]. Applying this to emergency services, the mapping exercise collected evidence of where services were placed on the continuum towards providing a dedicated pathway and/or a stand alone children's emergency service with its own waiting room and reception. All but three of the 133 emergency services mapped completed this section of the mapping. Therefore information was given for 129 emergency services.

Of these, 22 (15%) services had a stand alone emergency service for children and young people (Fig. 5.4a). Others were at different stages on the way to achieving this. 101 (78%) paediatric emergency services were located within A&E but separate facilities had been developed for children. In 89 (69%) services a separate waiting area was provided for children within A&E and in 88 (68%) services children's assessment and treatment was carried out in a separate area away from adult treatment. 117 paediatric emergency services (90%) had staff trained in paediatrics. In 94 (73%) of these services staff worked across adult and children's care, and in 66 (51%) services they worked only with children and young people. In 43 (37%) services some trained staff worked with both children and adults while others worked exclusively with children and young people.

Fig. 5.4a: Characteristics of paediatric emergency services (N=129)

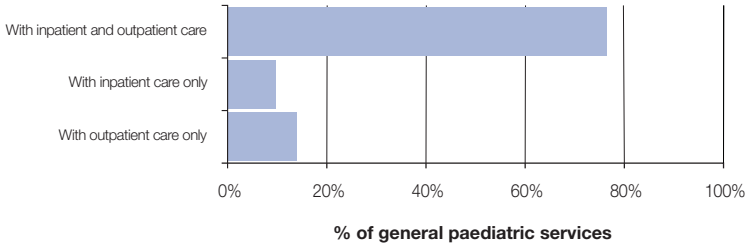


5.4.2 General Paediatric service characteristics

One of the aims of child health services is to increase the accessibility of general paediatric services through extending them into the community and ensuring better links between hospital and home. This can prevent hospital admission, facilitate early discharge and ensure ongoing support is easily accessed. The diversity of the settings of services' main base and outreach activities was investigated in Chapter 4. The mapping also collected information on paediatric inpatient and outpatient provision.

Of the 201 general paediatric services mapped, 147 (74%) offered both inpatient and outpatient provision. 19 (10%) services provided only inpatient care whilst 27 (14%) services were exclusively outpatient teams (Fig. 5.4b). Overall, 166 (86%) of the general paediatric services offered inpatient care and 174 (90%) services offered outpatient care.

Fig. 5.4b: Characteristics of general paediatric services (201)

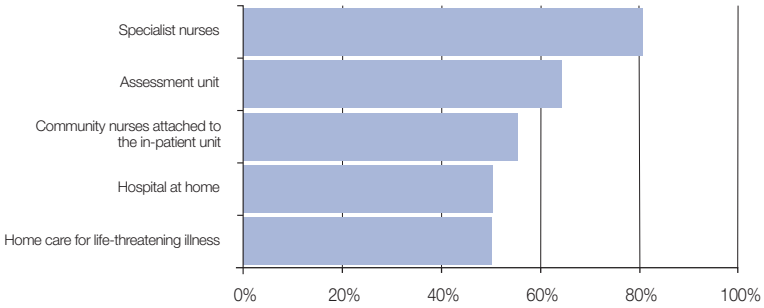


5.4.3 General Paediatric models of care

The aim of the Every Child Matters: Change for Children Programme[25] is to bring services closer to the child and his/her family. In order to track progress over time, services were asked to identify the model of care they currently provided. These questions were answered by 166 of the 201 general paediatric services mapped (83%). The different models of service reported are shown in Fig. 5.4c and included:

- Specialist nurses were available in 134 general paediatric services (81%)
- Specialist assessment units were provided in 107 services (64%)
- Community nurses attached to inpatient units were employed in 92 services (55%) to make links between home and hospital for children and their families
- Hospital at home services were provided by 84 services (51%). These were home nursing teams supporting children with acute, long term or complex health care needs who traditionally would have been cared for in hospital
- Home care for children with life threatening illnesses was provided in 83 services (50%) to enabling children to stay at home when they might previously have been admitted to hospital.

Fig. 5.4c: Alternative models to impatient care in general paediatrics (N=166)



5.4.4 Parent and carer management of medication in hospital

> Now a parent's presence is recognised as a positive factor in aiding the child's recovery; and their practical contribution to care at the bedside is often essential. Encouraging parents and children to take responsibility for administering their own medicines in hospital, where appropriate, prepares for discharge home and allows health care professionals to assess the child's and parents' abilities to cope, for example, with inhalers or more complex therapies.
>
> *National Service Framework for Children, Young People and Maternity Services*[26]

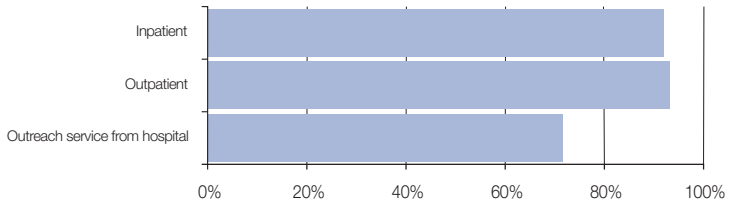
Parents and carers often stay with their children in hospital and, in order to increase parent/carer autonomy and build their confidence in caring for their child, they are often encouraged to manage their child's medication. This may mean taking responsibility for administering the correct dose of medicines but it may also involve learning how to give injections or increasing skills in other ways to prepare parents and carers for caring at home. Overall, 110 general paediatric services reported that they had developed these services. This was 55% of all general paediatric services and 67% of those with inpatient provision.

5.4.5 Diabetes services delivered through general paediatrics

The standards on the clinical care of children and young people with diabetes are found in the NSF for Diabetes[27]. The children's section focuses on early clinical assessment and management, continuity of care across all settings and transition to adulthood.

In total, 172 of the 201 general paediatric services mapped (86%) provided diabetes care. Most often services offered a combination of provision including inpatient units, outpatient services and outreach from the hospital ensuring good links were available between hospital and home care. Of the 172 diabetes services, 117 (68%) provided all three models of care. 160 services (93%) provided outpatient care, 158 (92%) provided inpatient care and 123 (72%) provided outreach (Fig. 5.4d).

Fig. 5.4d: Types of diabetes care provided by general paediatric services (N=172)

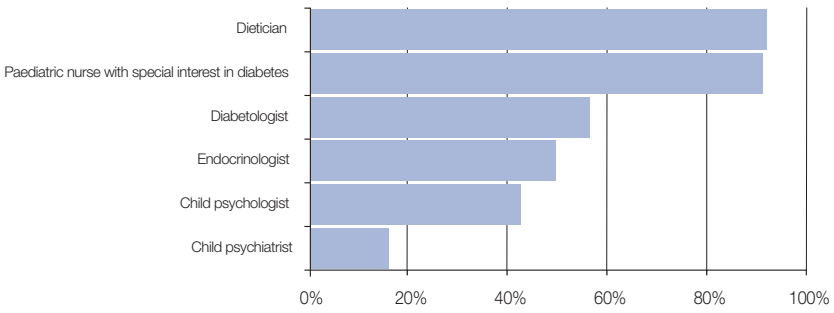


% of general paediatric services providing this type of diabetes care

All services (except one non-response) managed Type 1 diabetes while 146 services (85% of general paediatric services providing diabetes care) managed children and young people with Type 2 diabetes.

Children and young people with diabetes need access to a range of services and experts in child health and diabetes in order to minimise the risks involved in the long-term management of the condition. In the mapping, services were asked if their diabetic care had input from a range of specialists. It was found that input from specialists varied widely across the country. Dieticians were the most usual contributors, inputting into 158 (92%) of services (Fig. 5.4e). Children's nurses with a special interest in diabetes contributed to 157 (91%) of services. 97 (56%) of services had input from a diabetologist and 85 (49%) from an endocrinologist. Child psychology input was available in 73 (42%) of services but child psychiatry input was less usual and reported in only 27 services (16%).

Fig. 5.4e: Access to particular expertise for diabetes in general paediatric services (N=172)



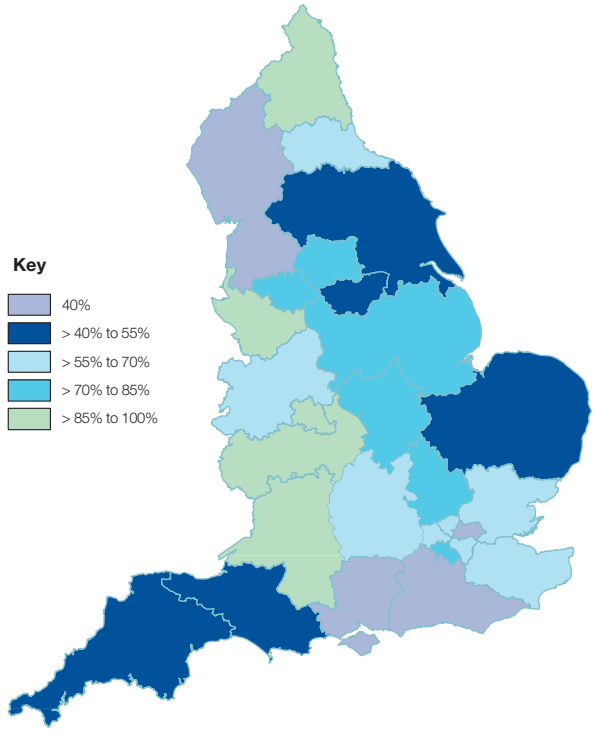
% of general paediatric services with access to particular expertise

5.4.6 Paediatric continence services

An integrated community-based paediatric continence service, informed by Good Practice in Paediatric Continence Service, ensures that accessible, high quality assessment and treatment is provided to children and their parents/carers in any setting, including, for example, children looked after and children at boarding schools.

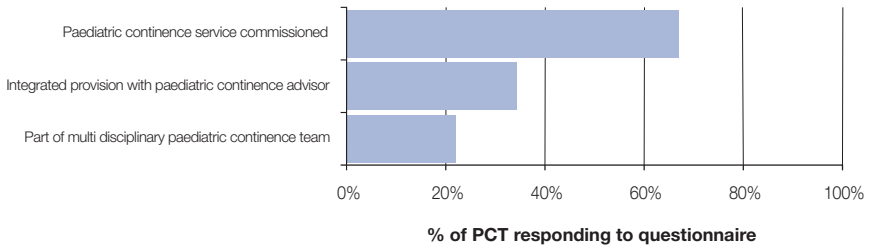
National Service Framework for Children, Young People and Maternity Services[28]

Map 5.4a: Proportion of PCTs in SHA that commission a paediatric continence service



Continence services for children have tended to be fragmented, each offering differing levels of care and split between hospital and community and yet a significant number of children suffer from nocturnal enuresis, daytime wetting and faecal incontinence[29]. In the mapping, PCT commissioners were asked to confirm whether they had a paediatric continence programme in place in their area. 162 PCTs (68% of those responding to the relevant questionnaire) reported that they commissioned a service (Map 5.5b). 81 (34%) PCTs commissioned integrated provision that linked acute and community services through the work of a paediatric continence advisor. In 53 (22%) PCTs the service that was commissioned was part of a multi-disciplinary paediatric continence team (Fig. 5.4f).

Fig. 5.4f: Paediatric continence services commissioned by PCTs (N=240)



5.4.7 Paediatric surgery

As the Day Surgery: Operational Guide (51) points out, day surgery is ideal for children, since overnight admission is often the most distressing part of visiting hospital for them.

National Service Framework for Children, Young People and Maternity Services[30]

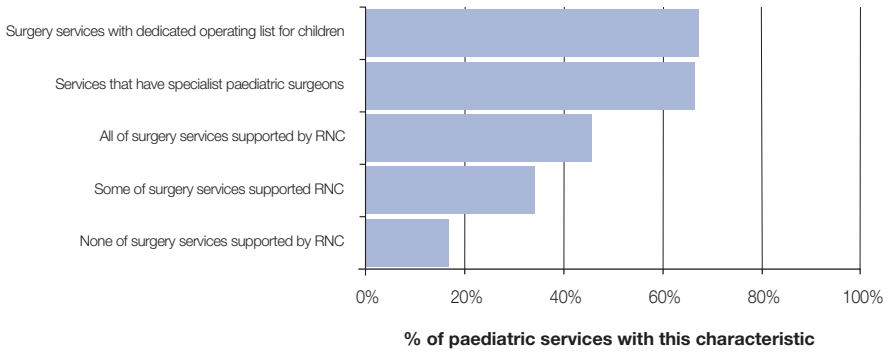
Dedicated operating lists for children are the ideal, but in many specialties this is not practical or feasible. In these circumstances, children should be put to the start of the list with appropriately trained staff in the reception, anaesthetic room, theatre and recovery areas.

National Service Framework for Children, Young People and Maternity Services[31]

Currently 149 of the 155 paediatric surgery services mapped (96%) offered day surgery in order to keep inpatient stays at a minimum and to provide, as far as possible, a community/child centred approach.

The mapping investigated the use of dedicated operating lists for children and the availability of staff trained specifically in the care of children in paediatric surgery units (Fig. 5.4g). Dedicated operating lists for children were found in 104 of the 155 paediatric surgery services mapped (67%). 103 (66%) services had specialist paediatric surgeons on their staff team. Operating lists were supported by nurses with child-specific training in 124 (80%) services but trained staff were only available for all children's surgery in 71 (46%) services. In the other 53 (34%) services, some surgery was supported by nursing staff who had not undergone specialist children's training.

Fig. 5.4g: Key features of paediatric surgery (RNC = Registered Nurse Children) (N=155)



Within the 155 paediatric surgery services mapped there were 199 consultants in post who were paediatric specialists (Table 5.4). That is consultants who, in addition to their formal professional training, had received child specific training, including Continuing Professional Development in the care of children and training in communication and assessment as required by the relevant specialist advisory committees.

The number of surgery cases carried out in a 12 month period in child specific operating lists and non-child specific lists was 163,624 but there was considerable variation between SHA. The national average of surgery cases per 100k population aged 0 to 17 years was 15 (Map 5.4b).

Map 5.4b: Surgery cases per year per 100k population aged 0-17

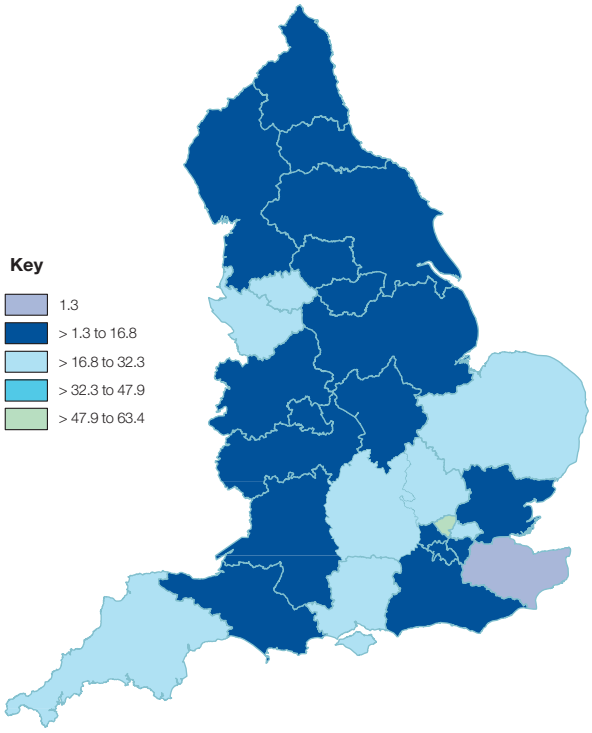


Table 5.4: Paediatric surgery and surgeons

Strategic Health Authority	Medical staff in post in surgery services	Surgeons that are paediatric specialists*	Surgery cases per year**	Surgery cases per year per 100k pop (0-17)
Avon, Gloucestershire & Wiltshire	46	7	7793	16
Bedfordshire and Hertfordshire	125	21	7244	19
Birmingham & the Black Country	49	7384	7384	13
Cheshire and Merseyside	94	11391	11391	22
County Durham & Tees Valley	166	4139	4139	16
Cumbria and Lancashire	54	4286	4286	10
Dorset and Somerset	49	3671	3671	15
Essex	54	4390	4390	12
Greater Manchester	17	10494	10494	18
Hampshire and Isle of Wight	73	9408	9408	24
Kent and Medway	1	468	468	1
Leicester, Northants & Rutland	16	1971	1971	6
Norfolk, Suffolk & Cambridgeshire	162	12309	12309	26
N & E Yorkshire & N Lincolnshire	18	1637	1637	5
North Central London	155	16537	16537	63
North East London	204	7057	7057	19
North West London	35	1343	1343	4
Northumberland, Tyne and Wear	25	3685	3685	12
Shropshire and Staffordshire	40	2628	2628	8
South East London	29	3291	3291	10
South West London	2	2522	2522	9
South West Peninsula	85	6546	6546	20
South Yorkshire	92	4681	4681	17
Surrey and Sussex	29	1447	1447	3
Thames Valley	107	11314	11314	23
Trent	15	6703	6703	12
West Midlands South	160	2831	2831	8
West Yorkshire	27	6454	6454	13
Total	**1928**	**163624**	**163624**	**15**

*Consultants in post in surgery services who have received child specific training, including Continuing Professional Development in the care of children and training in communication and assessment as required by the relevant specialist advisory committee, in addition to formal professional qualifications.
**Regardless of whether it is performed in a child specific operating list

5.4.8 Neonatal intensive care

Neonatal services aim to offer high quality care for some of the most vulnerable babies in our society. Approximately 10 per cent of babies require some form of specialist support at birth with 1-3 per cent of these requiring neonatal intensive care.

Neonatal Intensive Care Review[32]

The Neonatal Intensive Care Review recommended that the types of care that babies might require should be clearly defined in 3 levels, special care, high dependency and intensive care[33]. Neonatal intensive care units (NICU) may provide the full range of care but most would provide high dependency care and intensive care with special care baby units (SCBU) providing Level 1 special care. The review also recommended an increase in cot capacity and a strengthening of the role of SCBU to ensure the provision of high quality special care for babies. The mapping exercise collected information on SCBU within maternity services (see section 4.4) but to obtain a national summary of the cot numbers mapped, SCBU provision is reported here alongside that of NICU.

In total 2000 NICU cots were recorded in the mapping and 1,317 cots in SCBU.

Table 5.4: Neonatal intensive care unit provision

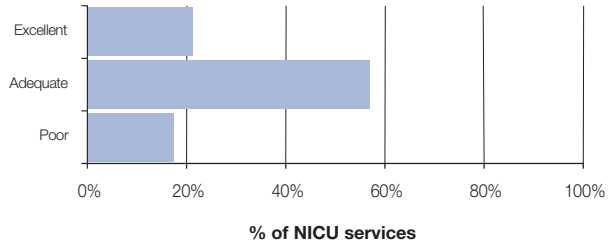
Strategic Health Authority	Number of NICU services*	Number of NICU cots**	Number of SCBU cots ***
Avon, Gloucestershire & Wiltshire	6	133	73
Bedfordshire and Hertfordshire	4	96	47
Birmingham & the Black Country	4	65	8
Cheshire and Merseyside	6	100	48
County Durham & Tees Valley	2	25	20
Cumbria and Lancashire	7	75	48
Dorset and Somerset	3	40	17
Essex	2	32	24
Greater Manchester	3	25	35
Hampshire and Isle of Wight	4	64	21
Kent and Medway	4	69	95
Leicester, Northants & Rutland	2	62	-
Norfolk, Suffolk & Cambridgeshire	5	94	55
N & E Yorkshire & N Lincolnshire	3	52	26
North Central London	4	89	59
North East London	4	98	67
North West London	4	92	51
Northumberland, Tyne and Wear	2	24	46
Shropshire and Staffordshire	2	42	-
South East London	4	106	121
South West London	2	40	28
South West Peninsula	3	58	52
South Yorkshire	5	68	47
Surrey and Sussex	2	37	23
Thames Valley	7	110	89
Trent	3	68	44
West Midlands South	3	32	63
West Yorkshire	9	204	98
Total	**109**	**2000**	**1305**

* Neonatal intensive care unit
** Neonatal intensive care cots including special care baby cots in neonatal intensive care units
*** Special care baby cots outside neonatal intensive care unit

The transfer of critically ill babies between units requires careful planning and co-ordination. Transport arrangements need to be in place both to support the movement of critically ill babies and also for babies being taken back to a unit near their homes[34].

The majority of services considered their transfer arrangements between maternity and neonatal intensive care units to be adequate. Of the 109 NICU services, only 23 (21%) reported excellent transfer while 62 services (57%) rated their transfer as adequate and 19 services (17%) felt their transport was poor (Fig. 5.4h).

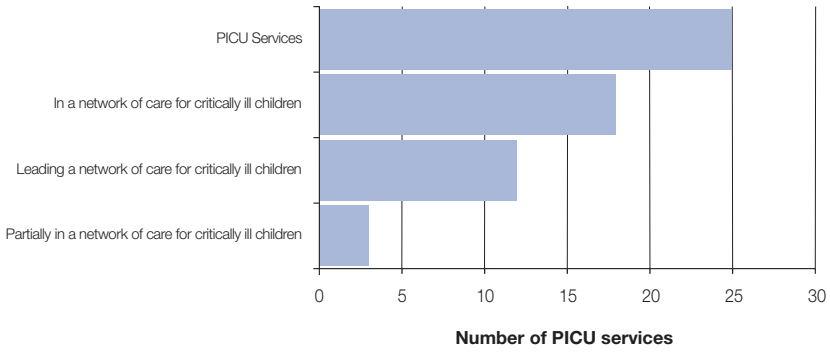
Fig. 5.4h: Adequacy of NICU access to neonatal transfer (N=109)



The Neonatal Review recommended that all neonatal care should be provided within agreed managed clinical networks comprising hospitals with differing types of neonatal units working together[35]. The purpose of each network would be to ensure, with only a limited number of exceptions, that mothers and babies receive their care within it or, very occasionally, within an adjacent network. Mothers should thus be able to receive their care as near to home as possible and to know in advance should a problem arise with their baby where and how care will be provided.

Of the 25 PICU services mapped, all but 1 belonging to a managed clinical network for critically ill children, three services were partial members and 12 indicated that they led the network (Fig. 5.4i).

Fig. 5.4i: Participation in PICU networks of care



5.5 Standard 8 - Disabled Children and Young People and Those with Complex Health Needs.

Children and young people who are disabled or who have complex health needs receive co-ordinated, high quality child and family-centred services which are based on assessed needs, which promote social inclusion and, where possible, which enable them and their families to live ordinary lives.

National Service Framework for Children, Young People and Maternity Services

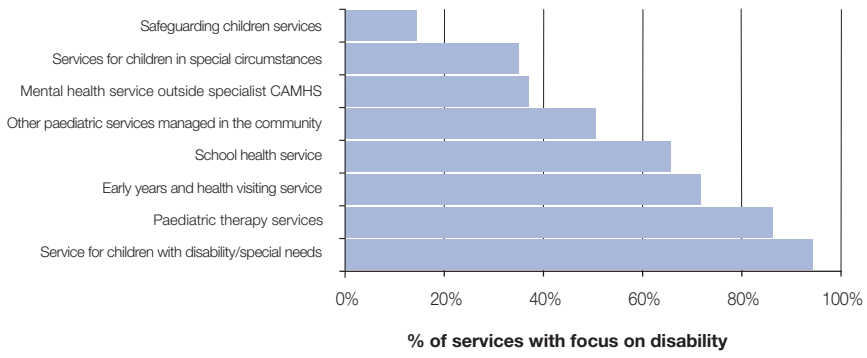
This standard relates to services for children with a disability and/or special needs, but this should not mask the high levels of support that children and young people with disabilities receive from other universal, targeted and hospital services.

The scope of disabilities supported is broad and includes learning disabilities, autistic spectrum disorders, sensory impairment, physical impairment and emotional/ behavioural disorders. In all these fields, policy aims for the reconfiguration of service provision to ensure that child-centred, multi-agency care is available that can respond promptly and effectively to need[36].

5.5.1 Focus on disability in universal and targeted services

The mapping data showed that disability was the concern of many universal and targeted teams (Fig. 5.5a). All services specifically for children with disabilities and special needs had this focus (although returns were incomplete in 6% of services). A high proportion of paediatric therapy (86%), early years and health visiting (72%) and school health services (66%) also identify a focus on working with disabled children and young people. Just half of other paediatric services managed in the community indicated this focus.

Fig. 5.5a: Focus on disability in universal and targeted services (N=1,383)



Looking at the different disability support services (Table 5.5a), services tended to work across the range of physical and learning disabilities, autistic spectrum disorders and sensory impairment to an almost equal degree. The only exception was children with complex health disorders, who were the focus of specialist services for children with disabilities.

Table 5.5a: Proportion of universal and targeted services working with children and young people with particular disabilities (N=1,383)

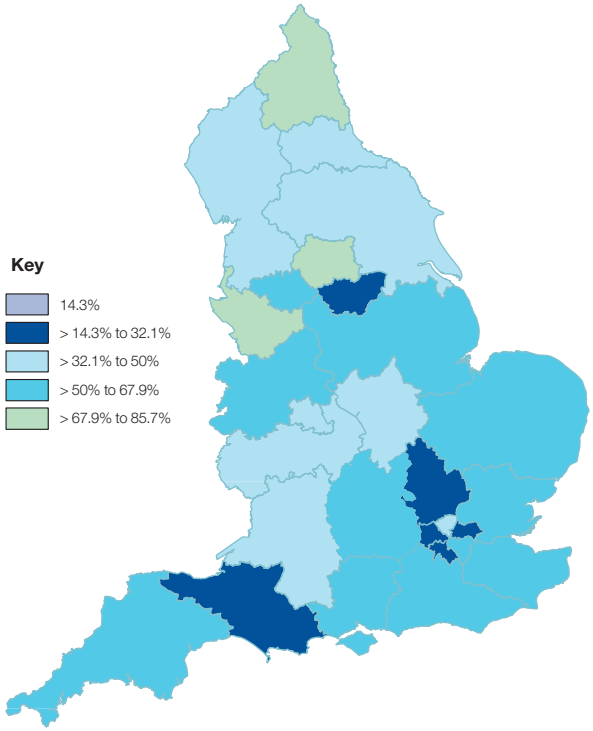
	Physical disability	Learning disabilities	Sensory impairment	Autistic spectrum disorder	Other disabilities	Couplex health disorders
Safeguarding children services	7%	8%	7%	7%	7%	-
Early years and health visiting services	65%	62%	59%	61%	50%	-
Mental health services outside specialist CAMHS	23%	27%	23%	27%	23%	-
Other paediatric services managed in the community	44%	39%	37%	32%	40%	-
Paediatric therapy services	79%	73%	69%	61%	71%	-
School health services	53%	51%	50%	47%	46%	-
Services for children with disability / special needs	87%	82%	76%	74%	76%	83%
Services for children in special circumstances	24%	25%	20%	18%	18%	-
Total	**40%**	**38%**	**36%**	**34%**	**34%**	**8%**

5.5.2 Features of services for children with disabilities and special needs

Keyworker
A keyworker is both a source of support for the families of disabled children and a link by which other services are accessed and used effectively. Keyworkers have responsibility for working together with the family and with professionals from their own and other services and for ensuring delivery of the plan for the child and family. Workers performing this role may come from a number of different agencies, depending on the particular needs of the child[37].

Good practice recommends that a keyworker system is in place to support disabled children with high levels of need. Keyworkers support parents of severely disabled children by providing a single point of contact with services and a trusted, informed named person to help them access the services that they require[38]. However, in the mapping it was found that less than half of the specialist disability services for children had adopted a keyworker system. Nationally 165 (48%) of the 343 services for children with disabilities and special needs had a keyworker system (Table 5.5b). Only half of SHAs exceed this average (Map 5.5a).

Map 5.5: Percentage of services for children with disabilities with a keyworker system in place (N=343)



To improve the quality of care for disabled children and their families, emphasis has been placed on training to ensure that staff have the right skills to provide high quality assessment, diagnosis, treatment and ongoing care to children, young people and their families[39].

In 183 (53%) services for children with disabilities and special needs, all staff had been trained to work specifically with children (Fig. 5.5b). In 127 (37%) services some staff had received training but in 24 (7%) of these services it was reported that no staff had received child specific training. Specialist nurses worked in an extended role in disability in 134 (48%) services.

Fig. 5.5b: Training and specialisms of staff on working with children in services for children with disabilities and/or special needs

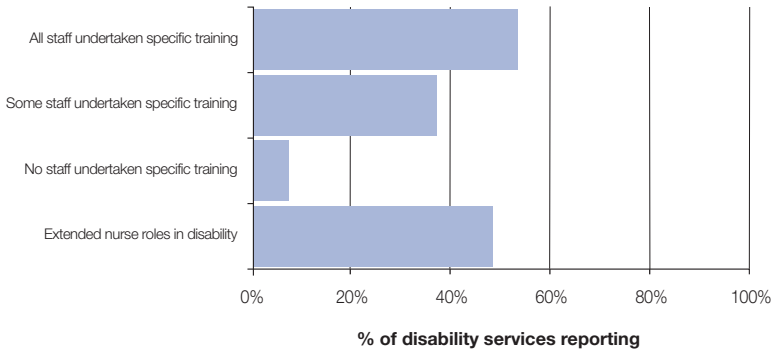


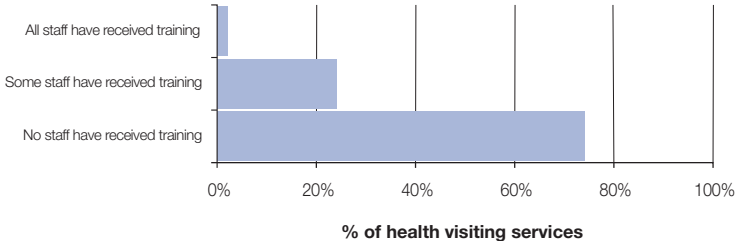
Table 5.5b: Features of services for children with disabilities and special needs

Strategic Health Authority	Number of services dedicated to children wih a disability / special needs	Disability services with keyworker system	No staff have undertaken specific training to work with children	Some staff have undertaken specific training to work with children	All of staff have undertaken specific training to work with children	Disability staff with extended role[1]
Avon, Gloucestershire & Wiltshire	19	47%	16%	37%	47%	41%
Bedfordshire and Hertfordshire	11	27%	9%	73%	18%	4%
Birmingham & the Black Country	24	42%	8%	38%	46%	23%
Cheshire and Merseyside	7	86%	-	43%	57%	72%
County Durham & Tees Valley	17	41%	-	35%	65%	21%
Cumbria and Lancashire	23	48%	13%	44%	39%	43%
Dorset and Somerset	6	33%	17%	50%	17%	22%
Essex	10	60%	30%	40%	30%	10%
Greater Manchester	13	62%	31%	23%	39%	90%
Hampshire and Isle of Wight	17	53%	-	12%	88%	40%
Kent and Medway	22	55%	5%	41%	55%	32%
Leicester, Northants & Rutland	5	40%	-	40%	60%	-
Norfolk, Suffolk & Cambridgeshire	17	53%	-	41%	59%	22%
N & E Yorkshire & N Lincolnshire	9	33%	11%	33%	56%	61%
North Central London	13	46%	-	23%	77%	25%
North East London	9	22%	11%	67%	22%	18%
North West London	10	30%	-	10%	90%	24%
Northumberland, Tyne and Wear	11	73%	-	27%	64%	42%
Shropshire and Staffordshire	8	50%	-	25%	75%	17%
South East London	14	64%	-	43%	57%	24%
South West London	11	18%	-	36%	64%	43%
South West Peninsula	10	50%	-	30%	60%	41%
South Yorkshire	7	14%	-	57%	14%	93%
Surrey and Sussex	4	50%	25%	75%	-	515%
Thames Valley	10	50%	-	30%	70%	19%
Trent	10	50%	10%	30%	60%	21%
West Midlands South	15	47%	13%	33%	47%	1%
West Yorkshire	11	82%	-	46%	55%	93%
Total	**343**	**48%**	**7%**	**37%**	**53%**	**48%**

5.5.3 Health visitors and disability

36% of health visitor services have staff practising an extended role in disabilities.
In 74% of early years and health visiting services, no health visiting staff had received specific training on working with disabled children (Fig. 5.5c).

Fig. 5.5c: The development of an extended nurse role in disabilities in early years and health visiting services (N=484)



5.5.4 Disability services for adolescents

Only 11 disability services reported that they provided specifically for adolescents.

Table 5.5c: Services for adolescents with disabilities and/or special needs.

Strategic Health Authority	Disability services for adolescents	Services for adolescents as a % of disability services
Birmingham and the Black Country	2	8%
Cumbria and Lancashire	1	4%
Greater Manchester	1	8%
Hampshire and Isle of Wight	2	12%
North East London	1	11%
North West London	2	20%
South West London	2	18%
Total	**11**	**3%**

5.6 Standard 9 - the Mental Health and Psychological Well-being of Children and Young People.

All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality multi-disciplinary mental health services to ensure effective assessment, treatment and support, for them, and their families.

National Service Framework for Children, Young People and Maternity Services

Standard 9 covers all levels of CAMHS services but the child health and maternity service mapping concentrates on tier 1 provision provided by non-specialist CAMHS. This is because tier 2 to 4 CAMHS are mapped in a separate national exercise, the results of which can be explored at www.camhsmapping.org.uk. Tier 1 CAMHS are often the first-line services that children and families access. Alternatively, tier 1 services tend to have direct contact with children and young people and have a role in providing information and promoting good mental health in a supportive environment.

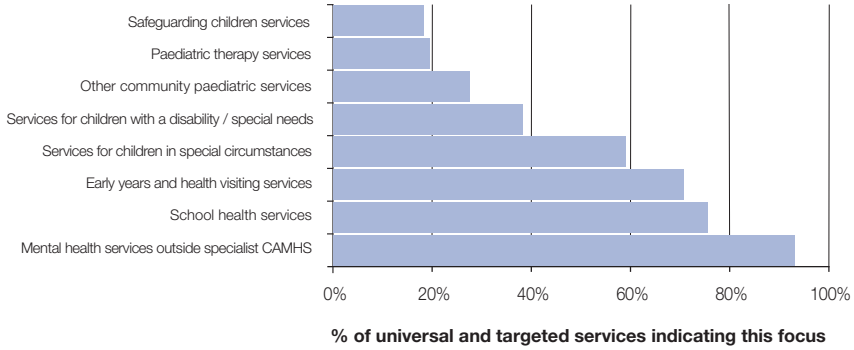
The service type aligned to this standard is the targeted service, mental health services outside of specialist CAMHS, but many child health services encounter children with mental health problems and difficulties. In particular there is a high incidence of mental health problems amongst disabled children and young people, children with long-term conditions and vulnerable children.

In addition to the NSF the information here is also linked to Together We Stand[40], Children in Mind[41] and Improvement, Expansion and Reform[42].

5.6.1 Focus on mental health in universal and targeted teams

In the mapping, mental health was identified as a focus of work by all responding mental health services and the majority of family and school-based health services (Fig. 5.6a). 245 (76%) school health services identified this focus and 344 (71%) early years and health visiting services. 145 (59%) services for children in special circumstances and 130 (38%) services for children with a disability/special needs also reported having a mental health focus but only a relatively small number of other services highlighted this as an area of work.

Fig. 5.6a: Focus on mental health in universal and targeted teams



5.6.2 ADHD provision

ADHD clinics were reported in 61 (15%) of the 396 community paediatric services and the time spent on ADHD tended to be small. In 1 service, over 75% of community paediatric staff time was spent on the delivery of ADHD services and in another, between 50% and 75% of their time was spent on this work but these were the exceptions. In 44 services (72%) less than 25% of community paediatric staff time was dedicated to ADHD and in 14 services (23%) staff spent between 25% and 50% of their time on it (Table 5.6).

Table 5.6: ADHD clinic provision

Strategic Health Authority	Community Paediatric Services With ADHD Clinics	Less than 25% staff time spent in ADHD clinics	25%-50% staff time spent in ADHD clinics	50%-75% staff time spent in ADHD clinics	More than staff time 75% spent in ADHD clinics
Avon, Gloucestershire & Wiltshire	1	1	-	-	-
Bedfordshire and Hertfordshire	3	2	-	1	-
Birmingham & the Black Country	4	4	-	-	-
Cheshire and Merseyside	4	1	3	-	-
County Durham & Tees Valley	-	-	-	-	-
Cumbria and Lancashire	4	1	2	-	1
Dorset and Somerset	1	1	-	-	-
Essex	1	-	1	-	-
Greater Manchester	1	-	1	-	-
Hampshire and Isle of Wight	1	1	-	-	-
Kent and Medway	5	-	4	-	-
Leicester, Northants & Rutland	1	1	-	-	-
Norfolk, Suffolk & Cambridgeshire	4	4	-	-	-
N & E Yorkshire & N Lincolnshire	1	1	-	-	-
North Central London	2	2	-	-	-
North East London	2	1	1	-	-
North West London	-	-	-	-	-
Northumberland, Tyne and Wear	1	1	-	-	-
Shropshire and Staffordshire	5	4	1	-	-
South East London	6	6	-	-	-
South West London	1	1	-	-	-
South West Peninsula	2	2	-	-	-
South Yorkshire	2	2	-	-	-
Surrey and Sussex	1	-	1	-	-
Thames Valley	-	-	-	-	-
Trent	3	3	-	-	-
West Midlands South	4	4	-	-	-
West Yorkshire	1	1	-	-	-
Total	**61**	**44**	**14**	**1**	**1**

5.7 Standard 11 - Maternity Services

Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies.

National Service Framework for Children, Young People and Maternity Services

High quality maternity care aims to promote women's experience in having choice and control in giving birth to their babies and to improve access to maternity services that support women during pregnancy, childbirth and the postnatal period[43].

5.7.1 PCT commissioning choice in maternity services

In order to identify the range of options available to women in local maternity services, PCTs were asked about the choice of maternity services they commissioned. Of the 240 PCTs that responded to the relevant questionnaire, 87% reported that they commissioned maternity services to ensure women could choose between alternative settings in which to give birth. PCTs were asked to identify from the following list, the range of options available to women in their area:

- A consultant-led maternity unit
- A midwifery-led unit adjacent to a consultant unit
- A stand alone midwifery-led unit where transfer by ambulance to an obstetric unit might be needed
- A home birth.

A choice of consultant-led or midwife-led care was commissioned by 75% of PCTs. However, only 29% of PCTs reported having stated in the service level agreement that choice must be offered. Across SHAs considerable variation from the national picture was found (Table 5.7a).

Table 5.7a: PCT commissioning of maternity services

Strategic Health Authority	Commissioning for choice of birth place*	Commissioning for choice of lead for care**	Commissioning for maternity choice in SLA***
Avon, Gloucestershire & Wiltshire	100%	67%	33%
Bedfordshire and Hertfordshire	82%	73%	9%
Birmingham & the Black Country	100%	56%	33%
Cheshire and Merseyside	77%	62%	31%
County Durham & Tees Valley	100%	100%	40%
Cumbria and Lancashire	100%	90%	20%
Dorset and Somerset	100%	89%	11%
Essex	92%	69%	31%
Greater Manchester	100%	100%	-
Hampshire and Isle of Wight	100%	80%	30%
Kent and Medway	86%	86%	43%
Leicester, Northants & Rutland	67%	67%	17%
Norfolk, Suffolk & Cambridgeshire	46%	46%	-
N & E Yorkshire & N Lincolnshire	90%	60%	50%
North Central London	80%	60%	40%
North East London	80%	80%	-
North West London	67%	50%	33%
Northumberland, Tyne and Wear	100%	100%	33%
Shropshire and Staffordshire	89%	89%	11%
South East London	100%	50%	50%
South West London	75%	75%	25%
South West Peninsula	100%	100%	27%
South Yorkshire	100%	100%	50%
Surrey and Sussex	100%	100%	-
Thames Valley	89%	67%	44%
Trent	81%	75%	38%
West Midlands South	100%	100%	50%
West Yorkshire	69%	69%	39%
Total	**87%**	**75%**	**29%**

* Proportion of PCTS who have completed a planning arrangements questionnaire and commission maternity services in a way which enables women to have a choice about where they give birth i.e. hospital or community.

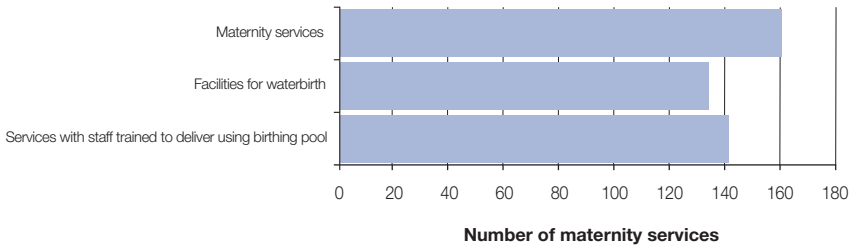
** Proportion of PCTS who have completed a planning arrangements questionnaire and commission maternity services in a way which enables women to have a choice of who leads their care.

*** Proportion of PCTS who have completed a planning arrangements questionnaire and service level agreement with providers make specific mention of the need to offer choice.

5.7.2 Water births

Wherever possible, women should have access to a birthing pool with staff competent in facilitating water births[44]. Of the 160 maternity services, 141 (84%) had staff trained in delivering in a birthing pool but only 134 (84%) services had the right facilities (Fig. 5.7a).

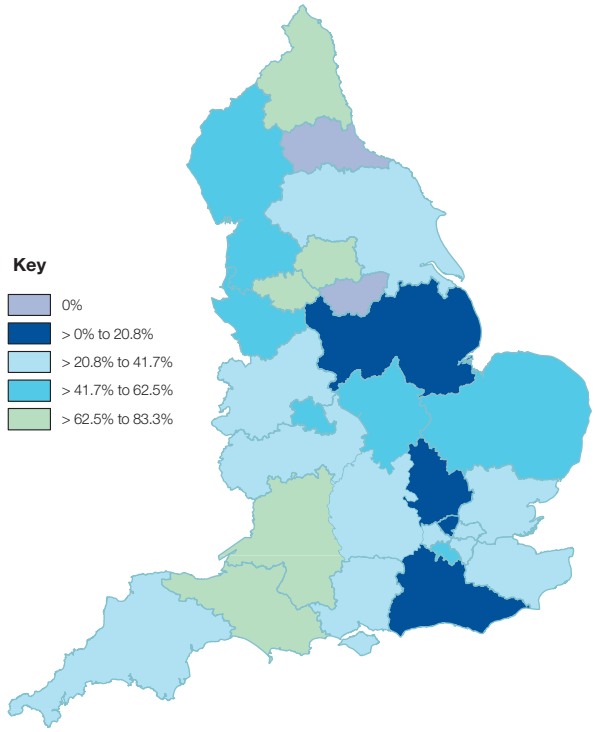
Fig. 5.7a: Maternity services with water birth facilities (N=160)



5.7.3 Community based postnatal care

Good practice recommends that midwifery-led postnatal care should be available for women and babies for at least one month after birth (or discharge from hospital) and for up to 3 months or longer depending on individual need[45]. Maternity services have set up dedicated community-based postnatal care teams to provide this flexible support for new mothers and babies and the mapping exercise found that 125 (78%) of the 160 maternity services provided this type of care (Map 5.7a).

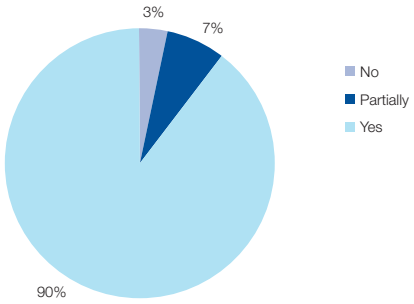
Map 5.7a: Dedicated community based postnatal care teams provision by SHA (N=160)



5.7.4 Involvement of partners in antenatal education

Pregnancy is one of the first opportunities to involve fathers in the care of their child and therefore prospective fathers are encouraged to engage in antenatal care[46]. The overwhelming majority of maternity services (90%) involved partners in antenatal education (Fig. 5.7b).

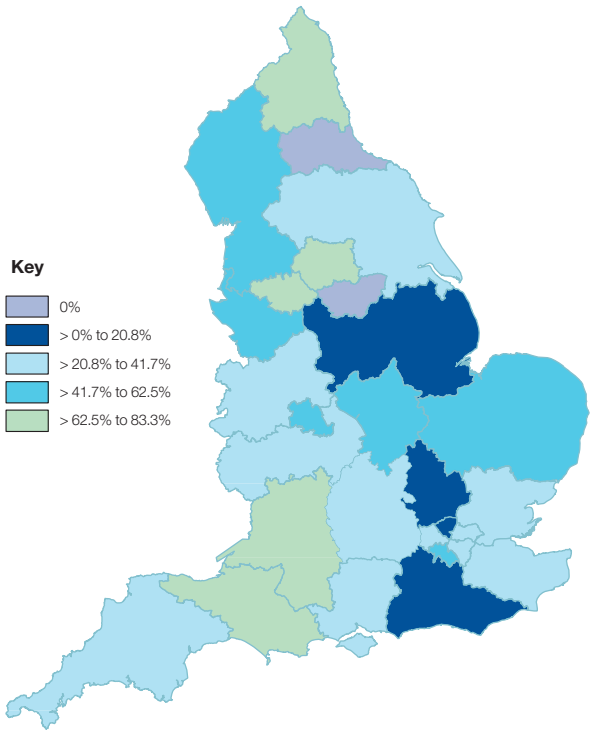
Fig. 5.7b: Involvement of partners in antenatal education



5.7.5 Maternity clinical networks

The purpose of Managed Maternity Care Networks is to ensure health professionals and all agencies contributing to the provision of maternity services and support work together in a co-ordinated way, thereby ensuring equitable provision of high quality, clinically effective care[47]. Only PCTs were asked about their involvement in Managed Maternity Networks and 41% were found to participate (Map 5.7b).

Map 5.7b: PCT participation in Managed Maternity Care Networks



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Annex 1. Technical notes on methodology

This annex provides an outline of the child health and maternity service mapping methodology.

A1 Basic mapping concepts

Key characteristics of child health and maternity service mapping include:

- Annual data collection
- Online data collection input by all NHS trusts that provide or commission child health and/or maternity services in England
- Service provision is mapped to 15 defined service types
- Describes services in terms of units of service delivery as defined by those inputting data
- Expenditure on child health and maternity services entered by PCT commissioners
- All data publicly available in reports on www.childhealthmapping.org.uk.

A2 Brief description of data collection process

- Introductory roadshow and telephone/email helpdesk provided throughout collection period and reporting period
- Child health and maternity services and commissioners identified by Children's Leads at Strategic Health Authorities
- Each NHS trust nominated a lead person to take responsibility for data returns
- Mapping Lead registered on the website and obtained a unique password giving access to that trusts data set
- Mapping Lead either completed team data or 'delegated' completion to a team manager
- Commissioning lead completed commissioning data online
- Data were checked, confirmed correct by mapping lead and 'signed off'
- Data were frozen on 28th February 2006 and reopened again for ongoing updates.

A3 Checks and reliability

Data scrutinised by Durham Mapping Team during preparation of this report and problems are checked with local informants.

Annex 2: Finance data quality

Strategic Health Authority	Number of PCT Commissioners	Registered PCT Commissioners	Number of spreadsheets completed[1]	Proportion of completed spreadsheets with estimated finance	Overall Commissioner Sign Off
Avon, Gloucestershire & Wiltshire	12	12	89	49.40%	12
Bedfordshire and Hertfordshire	11	11	92	57.60%	10
Birmingham & the Black Country	12	10	108	58.30%	9
Cheshire and Merseyside	15	14	89	29.20%	9
County Durham & Tees Valley	10	10	46	73.90%	8
Cumbria and Lancashire	13	13	73	56.20%	9
Dorset and Somerset	9	9	53	92.50%	8
Essex	13	13	117	26.50%	11
Greater Manchester	14	11	20	40.00%	2
Hampshire and Isle of Wight	10	10	59	89.80%	5
Kent and Medway	9	9	68	66.20%	8
Leicester, Northants & Rutland	9	9	40	85.00%	7
Norfolk, Suffolk & Cambridgeshire	17	14	52	51.90%	8
N & E Yorkshire & N Lincolnshire	10	10	51	52.90%	9
North Central London	5	5	99	75.80%	4
North East London	7	7	46	73.90%	2
North West London	8	8	83	74.70%	5
Northumberland, Tyne and Wear	6	6	35	88.60%	5
Shropshire and Staffordshire	10	10	84	63.10%	6
South East London	6	6	49	49.00%	4
South West London	5	4	23	39.10%	1
South West Peninsula	11	11	50	72.00%	10
South Yorkshire	9	5	2	100.00%	-
Surrey and Sussex	15	13	14	71.40%	1
Thames Valley	15	13	28	50.00%	6
Trent	19	19	72	54.20%	12
West Midlands South	8	8	53	39.60%	5
West Yorkshire	15	15	69	63.80%	9
Total	**303**	**290**	**1606**	**60.10%**	**185**

1. Including those entered by lead commissioners

Annex 3: Completion of components of service mapping (no. of services)

Strategic Health Authority	Services Provided	Services confirmed complete	School Health Services completing clusters question	Paediatric Emergency Services confirmed complete	Services that have completed the nurse prescribing question	Public health time spent completion	Services Completing Focus of work
Avon, Gloucestershire & Wiltshire	156	134	9	4	20	26	104
Bedfordshire and Hertfordshire	127	111	10	5	26	32	90
Birmingham & the Black Country	191	175	17	5	65	60	158
Cheshire and Merseyside	130	115	9	5	21	25	84
County Durham & Tees Valley	129	115	10	7	20	21	90
Cumbria and Lancashire	153	136	12	2	25	29	121
Dorset and Somerset	89	87	9	7	17	20	63
Essex	139	134	18	4	34	38	121
Greater Manchester	78	76	7	4	23	24	51
Hampshire and Isle of Wight	134	91	14	1	27	32	108
Kent and Medway	135	123	8	6	17	20	102
Leicester, Northants & Rutland	109	109	20	1	37	41	87
Norfolk, Suffolk & Cambridgeshire	163	118	10	4	21	29	115
N & E Yorkshire & N Lincolnshire	100	98	13	4	25	27	76
North Central London	99	90	6	4	8	14	66
North East London	102	89	4	5	9	9	65
North West London	103	88	6	4	12	17	68
Northumberland, Tyne and Wear	107	81	7	3	14	18	83
Shropshire and Staffordshire	88	68	10	1	16	19	76
South East London	154	153	7	5	40	42	116
South West London	96	52	2	-	20	26	72
South West Peninsula	111	101	15	4	30	34	81
South Yorkshire	102	80	4	6	11	11	56
Surrey and Sussex	82	70	12	5	22	25	61
Thames Valley	142	129	12	5	25	34	93
Trent	121	78	12	1	28	32	88
West Midlands South	153	148	10	6	28	33	101
West Yorkshire	163	127	12	7	26	30	104
Total	**3455**	**2977**	**285**	**115**	**667**	**768**	**2501**

Annex 3: Completion of components of service mapping (cont.)

Strategic Health Authority	Services Provided	aServices Completing Focus of work public health	Services Completing Referral Sources	Service that have completed the extended nurse roles question	Emergency Service features completion	Models of care completion	Health visiting disability training completion	Antenatal function completion
Avon, Gloucestershire & Wiltshire	156	57	101	25	4	7	15	7
Bedfordshire and Hertfordshire	127	51	88	28	4	8	18	4
Birmingham & the Black Country	191	108	155	51	4	4	47	4
Cheshire and Merseyside	130	54	83	22	6	7	14	7
County Durham & Tees Valley	129	47	88	20	7	7	10	7
Cumbria and Lancashire	153	70	119	25	3	8	16	7
Dorset and Somerset	89	38	62	17	7	4	9	4
Essex	139	79	117	36	4	3	19	4
Greater Manchester	78	38	48	24	4	5	17	4
Hampshire and Isle of Wight	134	55	106	32	2	5	18	4
Kent and Medway	135	56	98	18	7	9	12	8
Leicester, Northants & Rutland	109	52	87	40	1	4	20	2
Norfolk, Suffolk & Cambridgeshire	163	58	110	26	6	9	15	6
N & E Yorkshire & N Lincolnshire	100	53	74	22	4	6	14	4
North Central London	99	30	65	9	4	5	5	4
North East London	102	36	63	9	5	6	6	5
North West London	103	40	66	11	4	4	10	5
Northumberland, Tyne and Wear	107	51	81	15	4	4	10	4
Shropshire and Staffordshire	88	45	72	17	1	2	10	2
South East London	154	75	112	27	5	6	25	9
South West London	96	35	72	21	4	6	19	3
South West Peninsula	111	60	81	27	4	5	18	10
South Yorkshire	102	36	56	11	7	8	7	5
Surrey and Sussex	82	36	60	22	4	3	11	3
Thames Valley	142	52	91	25	6	7	22	8
Trent	121	59	87	24	4	5	19	6
West Midlands South	153	53	98	23	6	9	19	8
West Yorkshire	163	58	100	29	8	10	14	9
Total	**3455**	**1482**	**2441**	**656**	**129**	**166**	**439**	**153**

Annex 4: Child Health and Maternity Service Mapping Steering Group

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